

A FAMILY ASYLUM:
A HISTORY OF THE PRIVATE MADHOUSE AT
TICEHURST IN SUSSEX, 1792-1917.

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ABSTRACT

Despite a recent burgeoning of interest in the history of psychiatry and institutions for the insane, there has been no full-length study of the history of a private asylum in England. The archives of Ticehurst Asylum, which was run by four generations of the Newington family between 1792 and 1917, offer a rich source for such a study. This thesis locates the asylum in both its social and medical contexts. Initially founded as a small private madhouse, it took a wide range of clientele, including some paupers. The published medical writings of Thomas Mayo (1790-1871), who was visiting physician to Ticehurst from 1817-36, and a published account by John Perceval of his stay at Ticehurst in 1832 mean that there is substantial evidence to place Ticehurst in the 1820s and 1830s within broader trends of social change, especially the influence of Evangelicalism on manners and morals, and the development of a diagnosis of 'moral insanity'. By the 1840s, Ticehurst had become an élite asylum for predominantly upper-class patients. Increased documentation required by the 1845 Lunacy Act means that a fuller profile can be drawn of medical and moral treatment at the asylum, and it is argued that emphasis by historians on the importance of moral treatment has led to insufficient emphasis being paid to the influence of psycho-physiology on asylum doctors'

practice, and Victorian medical therapeutics for mental disorders. Finally, the professional career of Herbert Francis Hayes Newington (1847-1917), who was president of the Medico-Psychological Association in 1889-90, provides the basis for a discussion of Ticehurst's location within the profession of psychiatry. This includes the conflict over the proposed closure, and eventual stricter regulation, of private asylums; and the difficulties faced by psychiatry in the absence of significant therapeutic advances in a period of rapid scientific development in other areas of medicine.

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INTRODUCTION

Despite a recent burgeoning of interest in the history of psychiatry and institutions for the insane, there has been no full-length study of the history of a private asylum in England. Parry-Jones' 1972 survey of private madhouses in England in the eighteenth - nineteenth centuries mapped out a rich territory for potential future research, but with the exception of his own detailed look at Hook Norton and Witney asylums in Oxfordshire, the archives of private madhouses remain largely unexplored.¹ Recent monographs on the history of individual institutions for the insane - by Digby, Thompson and, in the American context, Tomes - have focused instead on the history of private charity, or publically-funded, hospitals.² For this reason alone, a longer historical examination of the internal working of a private madhouse, and its location in a broader social context, would be worthwhile; but this study also aims to explore the evidence from Ticehurst Asylum in the light of current debates in the historiography of psychiatry, and to draw attention to issues which have not so far been raised by the agenda of 'provocative questions' which is the legacy of the wide-ranging historical surveys of the 1960s-70s by Foucault, Doerner and Scull.³

Ticehurst, indeed, would make a poor test-case by which

to assess Doerner's thesis that the main thrust behind psychiatric institutionalization was an offensive by the bourgeoisie against the idleness of the insane poor; or Scull's argument that the development of a mature capitalist economy fostered social conformity and a desire to segregate the disruptive and deviant from the community, freeing those who might otherwise have been tied by lunatic dependents at home to enter the marketplace. Although for the first 30-35 years after it opened in 1792 Ticehurst accommodated some pauper patients, from the outset the asylum's clientele were predominantly private, and became increasingly upper-class as the nineteenth century progressed. As Anne Digby and Nancy Tomes have argued in relation to the York Retreat and Pennsylvania Hospital respectively, it is difficult to apply arguments of 'social control' to institutions with a mainly bourgeois clientele, and this is even more clearly so in the case of Ticehurst, which unlike the Tukes' or Kirkbride's asylums had no charitable and philanthropic intentions behind its foundation. Tomes' work points fruitfully to the asylum's servicing of the needs of the family as an alternative source of explanation for the success of the Pennsylvania Hospital, and similarly this thesis will explore the ways in which the Newington family, who ran Ticehurst through four generations from 1792 - 1917, succeeded in satisfying the requirements of their

fee-paying clientele: that is patients' families rather than the patients' themselves.⁴

Although Foucault also linked the rise of the asylum to a clash between the work ethic and the disruptive and introspective behaviour demanded by madness, his emphasis on the centrality of the image of the bourgeois family to the late-eighteenth - early-nineteenth century asylum ideal means that his work is of pertinence to an understanding of the appeal of the asylum to the bourgeoisie for their own family members, as well as for the idle poor. Foucault saw the 'great confinement' of the insane partly as a consequence of 'the great confiscation of sexual ethics by family morality', which appointed 'The family and its demands ... [as] one of the essential criteria of reason'.⁵ For Foucault, the late-nineteenth - early-twentieth century understanding of insanity as a private intrafamilial or individual psychological problem, most notably in psychoanalysis, was an extension of the social marginalisation of the irrational in favour of reason, which had begun with the concrete institutionalization of the insane. If some eighteenth-century mad-doctors chained and beat their patients in an effort to tame their madness, their use of power was at least frank. Foucault believed that the early-nineteenth century lunacy reformers were kind only to be more insidiously cruel, manipulating emotional

bonds of affection and guilt to induce conformity and silence the irrational in a highly-organized and effective exercise of 'moral synthesis', which trapped the insane in a 'parental complex'.⁶ How far each of us is prepared to go with Foucault will depend on the extent to which we are willing to perceive familial bonds of affection and concern as fundamentally disingenuous and malevolent strategies to gain control. Foucault's analysis of lunacy reform suggests that it was not simply the hegemonic assertion of the values of one class over another, as the 'social control' theorists believe, but part and parcel of a more pervasive process of 'familialisation', which has enmeshed us all in a web of power relations and socially-constructed knowledge - discourses - which deprive us of a more direct and raw experience of desire and the irrational.⁷

As Anne Digby has pointed out, the family can be depicted as either nurturing and supportive, or constraining and destructive: Foucault exclusively emphasises the latter possibility, but most real families contain elements of both polarities.⁸ What is striking however is that this duality closely parallels the dichotomy which Klaus Doerner believed confronted psychiatry in the late-1960s: to choose whether it was primarily 'an emancipatory or integrative science, i.e. whether it aims more at the liberation of the mentally suffering or the disciplining

of bourgeois society'.⁹ Perhaps it is not surprising that the institution through which we are socialized as children, and the institutions to which we are sent if that socialization fails or is disrupted by illness, should have profound similarities. Foucault's analysis exaggerates the negative aspect of these interconnections, but his basic insight that the two are almost necessarily connected, and that early-nineteenth century 'psychiatry' was a fundamentally moral enterprise, is in certain respects more penetrating than Scull's perception of the asylum as a product of the disruption of eighteenth-century familial bonds by a mature capitalist economy, or Anne Digby's description of 'moral management' as a travesty of an earlier, more harmonious and domestic, 'moral treatment' generated by institutional inertia and rigidification.¹⁰ As an asylum which was relatively free of financial constraints, but clearly dependent on the continuing goodwill of patients' families, Ticehurst provides an excellent example through which to focus on the relationship between the family and the asylum.

It seems important to make it clear at this point that I do not see mental illness simply as a social construct, and asylum inmates as necessarily family or other social scapegoats. Like Nancy Tomes I believe mental illness 'involves both physiological and social processes'; and, I would want to add, psychological ones, which it may ultimately be possible to describe physiologically but

which are currently best analysed phenomenologically.¹¹ However I do not see it as the historian's task to make retrospective diagnoses or discuss whether or not asylum inmates were 'really' ill. It is more important for the historian to elaborate the way in which asylum inmates were perceived by their contemporaries and by themselves, and this is aided by a deliberate suspension of judgement and even-handed approach to all the varying contemporary interpretations of what was happening to the patient. Equally I believe psychiatry can best be described in its social aspects by historians who are concerned with its place in the whole contemporary culture, rather than in a delineation of psychiatric 'discoveries' and 'advances'. I am therefore concerned with psychiatry's medical effectiveness only in so far as this was one factor which influenced the way in which asylum practice was perceived by the general public; and an equally important and continuous theme is how well psychiatry related to prevailing standards and ideals of moral and social behaviour.

Unlike the Retreat, which after the publication of Samuel Tuke's Description of the Retreat (1813) stood as the reformers' symbol of enlightened asylum practice, Ticehurst did not enjoy a particularly prominent reputation in the early-nineteenth century; nor, on the other hand, did it become notorious for malpractice like

Thomas Warburton's Red and White Houses in Bethnal Green. In 1877 Lord Shaftesbury told a Commons select committee that to close down Ticehurst 'would be a positive loss to science and humanity', but there is little evidence of when and how this substantial later-nineteenth century reputation was quietly established.¹² To twentieth-century historians of psychiatry however, Ticehurst has become something of a symbol: it is one of the four private madhouses apart from Hook Norton and Witney which Parry-Jones describes in some detail, suggesting that 'Throughout the nineteenth century, Ticehurst held a high reputation as an asylum for the wealthier classes'; perhaps on account of this exceptional reputation it is the institution Andrew Scull primarily focuses on to argue that 'rich [Victorians] could buy greater attention and more eminent psychiatrists for their crazy relatives, but not more cures'; and it is one of the asylums which Roy Porter has cited as operating de facto principles of moral treatment before the influence of Pinel and Samuel Tuke.¹³ How far the lavish imagery of Ticehurst in the mid - late nineteenth century - the aristocratic patients, extensive grounds, a pack of harriers and numerous staff - can be extended to Ticehurst's early history with historical accuracy will be the main question explored in the first chapter.

For the early period the only records available are accounts, so that it is difficult to do more than speculate tenuously about the reasons why Ticehurst was originally established, and the medical and moral philosophy which informed treatment under Samuel Newington (1739-1811). After 1817 however the published writings of Thomas Mayo (1790-1871), who was visiting physician to Ticehurst from 1817-36, and a published account by a former patient, John Perceval, of his stay at Ticehurst in 1832 mean that there is substantial evidence to locate Ticehurst in the 1820s and 1830s within broader trends of social change. Chapter 2 will explore the ways in which Ticehurst was influenced by the Evangelical call for a thoroughgoing reform of the manners and morals of the nation, and Thomas Mayo's role in the development of a diagnosis of 'moral insanity'. A revision of the standards by which family life should be conducted was central to the Evangelicals' campaign, and the implications of this for Charles Newington's (1781-1852) and Thomas Mayo's relationships with their patients' families will be elaborated. In addition Perceval's and Mayo's writings make it possible to describe more fully the kind of medical and moral treatment which was offered at Ticehurst in the 1820s-1840s than in the first years after the asylum opened.

The study of a single institution provides an opportunity to explore the impact of national trends, and changes in medical theory and practice on local, and in the case of Ticehurst, familial traditions. Chapter 3 looks first at the impact of the 1845 Lunacy Act on Ticehurst.

Increased documentation required by this legislation makes it possible to draw a clearer profile of the asylum's inmates, in terms of their age, marital status and social class. In addition, the medical case books kept after 1845 mean that far more is known about the moral and medical treatment of patients, so that it is possible to assess critically Andrew Scull's verdict that the main form of treatment offered by institutions like Ticehurst was 'moral treatment ... with a vengeance'.¹⁴ I hope to show that the relationship between mind and body, and moral and medical treatment, was perceived in Victorian psychophysiology as one of fluid interchange rather than rigid separation. Finally, correspondence in the case notes and evidence from published letters, diaries, autobiographies and biographies will be used to round out the picture of Charles Hayes (1813-63) and Samuel Newingtons' (1814-82) relationships with Ticehurst's clientele.

Herbert Francis Hayes Newington (1847-1917), who became joint-proprietor of Ticehurst with his uncle Samuel in 1875, was more active than his predecessors in the

Medico-Psychological Association, of which he was president in 1889-90. His more prominent professional career provides the basis in chapter 4 for a discussion of Ticehurst's location within the profession of psychiatry during a period of considerable agitation for the closure of private asylums, and a relatively bleak period for therapeutic initiatives and research. Hayes Newington's published writings enrich a reading of his day-to-day treatment of patients in Ticehurst, making it possible to assess the continuing importance of moral precepts to his practice as a psychiatric physician. Although a social profile of the asylum's inmates during this later period will be drawn, Hayes and Alexander Newingtons' (1846-1914) relationships with patients' families will be described in less detail. The Ministry of Health's directive on the confidentiality of hospital patient records (H.M.(61)73) does not cover private hospital records, but I have followed its recommendation that patients should not be individually named until their records are 100 years old. A full elaboration of the social context of referral and committal is therefore not possible after 1886. Instead the way in which Hayes Newington strove to secure the asylum's future at a political and professional level will be described, and I hope that this will illuminate the particular difficulties faced by psychiatry as it failed to keep pace with the rapid developments taking place in other

fields of medicine in the late-Victorian - Edwardian era. Whilst we now have a rich historiography of Victorian medical psychology, with the exception of Michael Clark's thesis on British psychiatric theory between 1850-1900, relatively little work has been done up until now on this later period.¹⁵

Although this thesis addresses primarily historical questions, I hope it will be read by psychiatrists as well as by historians. As Michael Shepherd has argued, psychiatry is 'closely embedded in the social matrix in which the subject is practised',¹⁶ and I believe one of the values of the history of psychiatry is to help illuminate that matrix. The conclusion will very briefly link the main arguments of this thesis to some contemporary debates in psychiatry.

Finally, a statistical survey of the available records was carried out for the entire period covered by this thesis; and this analysis forms the basis for much of the argument which follows. However, it seems important to stress that Ticehurst was a relatively small institution, never housing more than about eighty patients at any one time, and any attempt to generalize from these statistics about overall psychiatric trends in nineteenth-century Britain would be misguided. Similarly, whilst I want to emphasise that in its early history Ticehurst was more

'ordinary' than its current image in the historiographical literature suggests, I do not see it as in any sense 'typical' or necessarily representative of nineteenth-century psychiatric practice as a whole: wherever possible the evidence from Ticehurst will be linked to what is known of other individual asylums through the work of Parry-Jones, Anne Digby and Margaret Thompson, but these comparable studies reflect as many differences as similarities between Ticehurst and other asylums.

INTRODUCTION: NOTES

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2. Anne Digby, Madness, Morality and Medicine. A Study of the York Retreat, 1796-1914, (Cambridge & New York: Cambridge University Press); Margaret Sorbie Thompson, 'The Mad, the Bad and the Sad: Psychiatric Care at the Royal Edinburgh Asylum (Morningside), 1813-94', (Boston University PhD thesis, 1984), shortly to be published in book form; Nancy Tomes, A Generous Confidence. Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-83, (Cambridge & New York: Cambridge University Press, 1985).
3. Michel Foucault, Madness and Civilisation. A History of Insanity in the Age of Reason (London: Tavistock Publications, 1967); Klaus Doerner, Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry (Oxford: Blackwell, 1981); Andrew Scull, Museums of Madness. The Social Organization of Insanity in Nineteenth-Century England, (London: Allen Lane, 1979). Andrew Scull referred to the legacy of 'provocative questions' left by the general surveys of the 1960s-70s in his review of Nancy Tomes' study of the Pennsylvania Hospital, Journal of Social History, 19 (1986), p.521.
4. Nancy Tomes, op.cit. note 2, pp.x1, 12 & chapter 3; Anne Digby, op.cit. note 2, p.8.
5. Michel Foucault, op.cit. note 3; and quote from Alan Sheridan, Michel Foucault. The Will to Truth., (London: Tavistock Publications, 1980), pp.27-8.
6. Michel Foucault, op.cit. note 3, pp.253 & 260.
7. See Alan Sheridan, op.cit. note 5, p.34. This argument is extended in Foucault's later work, most notably The history of Sexuality, vol.1: An Introduction., (London: Allen Lane, 1979).
8. Anne Digby, op.cit. note 2, pp.57-8.
9. Klaus Doerner, op.cit. note 3, p.291.
10. However Anne Digby does emphasise that there were also disciplinary elements in 'moral therapy', op.cit. note 2, pp.85-7; Andrew Scull, op.cit. note 3, p.34.

11. Nancy Tones, op.cit. note 2, p.xii.
12. Report from the Select Committee on Lunacy laws; together with the Proceedings of the Committee, Minutes of Evidence, and Appendix (PP1877.XIII.1-), p.546.
13. William Ll. Parry-Jones, op.cit. note 1, pp.119-21; Andrew Scull, op.cit. note 3, pp.205-8; Roy Porter, 'Was there a Moral Therapy in Eighteenth-Century Psychiatry?', Lychnos, (1981-2), p.12.
14. Andrew Scull, op.cit. note 3, p.207.
15. Michael Clark, ' 'The Data of Alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850-c.1900', (Oxford University D.Phil. thesis, 1982).
16. Michael Shepherd, The Psychosocial Matrix of Psychiatry. Collected Papers., (London: Tavistock Publications, 1983), p.ix.

CHAPTER 1: THE FIRST TWENTY-FIVE YEARS, 1792-1817

No documentary evidence exists of the reasons a private madhouse was opened at Ticehurst, Sussex in 1792.

Historians have attributed the increase in the number of private and charitably-funded madhouses in the late-eighteenth and early-nineteenth centuries to the impact of industrialisation on earlier family and community responses to mental disorder. At first sight, it seems plausible that wage-dependent families who worked outside the home would be less able to care for or support a non-productive member; and that increasingly anonymous urban populations might be less tolerant of deviant or bizarre behaviour.¹

Yet, as Andrew Scull has convincingly argued, the proliferation of institutions for the insane antedated extensive urbanization; and, with the exception of Lancashire and the West Riding of Yorkshire, the most urbanized counties were slow to respond to legislation permitting the erection of county asylums in 1808.²

Clearly, in a county as rural as Sussex still was in the 1790s, urbanization can have been of little consequence.

It seems more likely that the decision to open an asylum at Ticehurst followed on the expansion of public interest in the treatment of insanity, aroused by the illness of

King George III in 1788-9. In 1792, apart from Ticehurst, a lunatic asylum was opened in the grounds of Liverpool Infirmary; abuses discovered at the York Asylum led local Quakers to found the Retreat (opened in 1796); new facilities for the insane were proposed at Leicester Infirmary (and opened in 1794); and in Gloucester, Sir George Onisepherous Paul (1746-1820) unsuccessfully attempted to introduce similar proposals at the infirmary there.³ All these were charitable initiatives, but the apparently successful treatment of the King by Dr Francis Willis (1718-1807) enhanced mad-doctors' claims to special expertise in treating the insane, in a way which might have appealed to middle and upper-class families for their own madfolk, as well as as benefactors to the poor.

Locally, the well-established and benign practice of William Perfect (1737-1809) at his private madhouse in West Malling in Kent, only seventeen miles from Ticehurst, created a grounding of public opinion on which the new asylum could build. A county historian and Canterbury school-teacher, Charles Seymour, described Perfect in 1776 as treating his patients:⁴

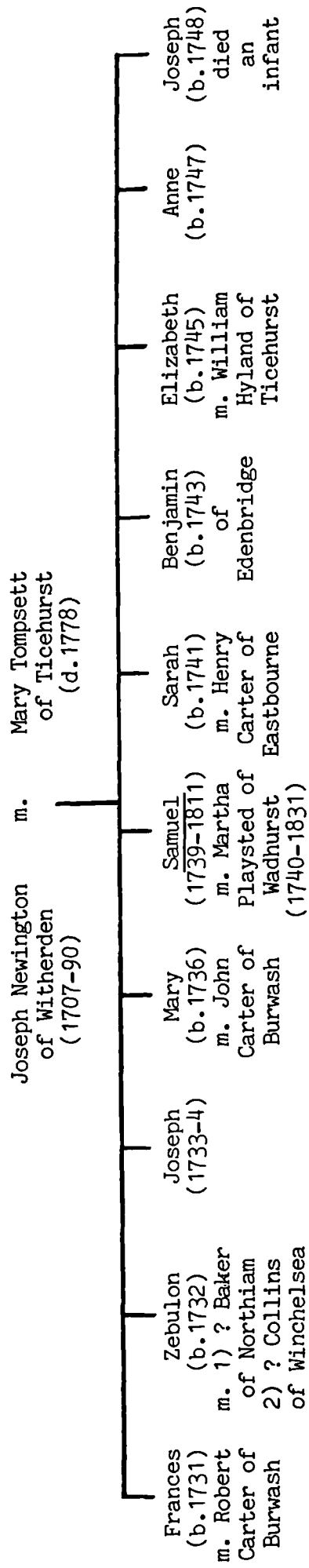
... with the affection of a parent and the abilities of a man, who has, from study and observation, reduced into a practical science, the method of restoring the most wild and fixed madness, to cool sense and rational judgement.

The author of several medical texts promoting his methods

of treatment, William Perfect favoured using only a minimum of restraint, with attention to diet and some medicine.⁵ Perhaps fearing the competition from Ticehurst (which had opened in August), William Perfect placed an advertisement for West Malling next to one for Ticehurst in the Sussex Weekly Advertiser for 26 November 1792.⁶

The Newingtons may also have hoped to benefit from their proximity to the spa-town of Tunbridge Wells, only ten miles from Ticehurst. The chalybeate springs of Tunbridge Wells had become renowned in the seventeenth century for their reputed medicinal properties, notably in the treatment of infertility and (of particular interest in this context) of melancholia.⁷ Aided by its proximity to London, Tunbridge Wells became a fashionable health-resort of the aristocracy in the late-seventeenth and early-eighteenth centuries.

Throughout the second half of the eighteenth century, however, Tunbridge Wells declined in popularity. In his writings, William Perfect touted the benefits nervous patients could derive from drinking the waters of chalybeate springs.⁸ However, by the 1790s, Tunbridge Wells faced severe competition from the increasingly fashionable sea-bathing resort of Brighton, and more distant spa-towns like Cheltenham, which was patronized

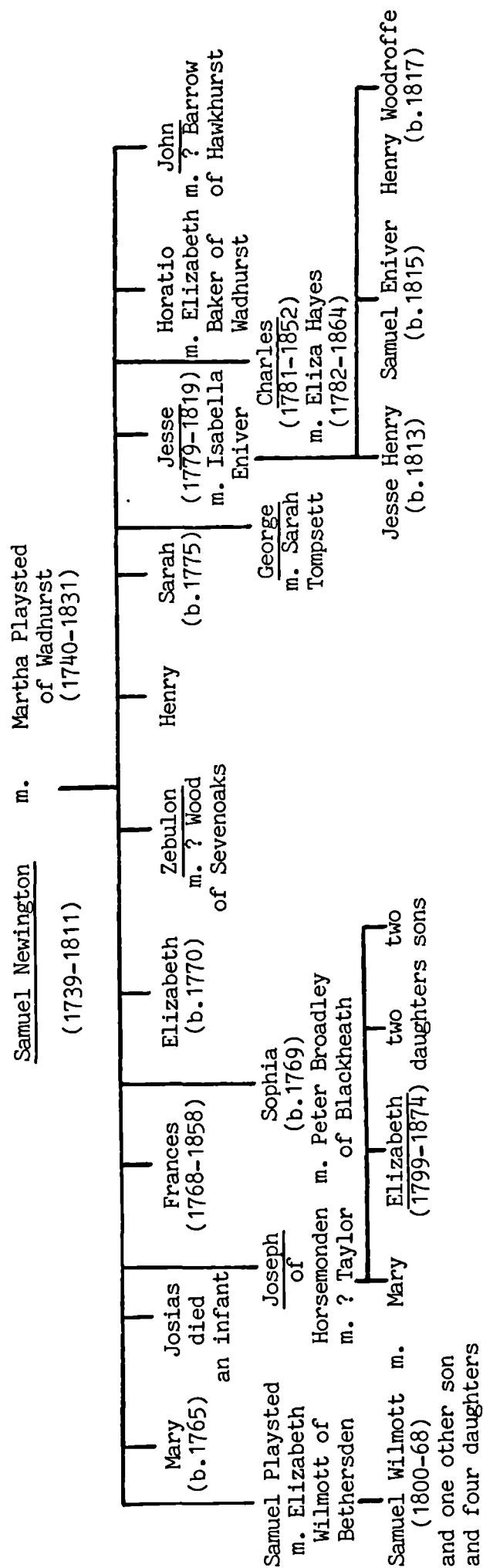


NEWINGTON FAMILY TREE: I

by King George III during his illness of 1788. In 1793, the 'Pantiles' - the cobbled streets of Tunbridge Wells - were re-laid with paving stones and, in emulation of Brighton, re-named the 'Parade'. Although local interest in restoring Tunbridge Wells to its former prosperity as a spa-town ultimately proved unsuccessful, its eventual re-shaping as a gentrified, residential new-town of the Regency period ensured an affluent local clientele.⁹

It is, therefore, possible to re-construct some of the grounds for Samuel Newington's market confidence when Ticehurst was opened. The personal reasons underlying his decision to become a madhouse-keeper are more difficult to ascertain. Unlike some of his contemporaries, who decided to open madhouses at this time, like Edward Long Fox (1761-1835) in Bristol, and William Tuke (1732-1822) in York, Samuel Newington had no non-conformist religious affiliations.¹⁰

The Newington family had lived in Ticehurst since the fifteenth century.¹¹ Little is known of Samuel Newington's parental family, except that he was the fifth of ten children (see Newington Family Tree I). Like William Perfect, Samuel Newington was a village surgeon and apothecary before he became a private-madhouse keeper.¹²



NEWINGTON FAMILY TREE: II

Advertisements for the new asylum suggest that, although he was not licensed as a madhouse-keeper, and since 1774 could legally only have cared for one patient at a time (14, Geo.III, c.49), Samuel Newington may have treated mentally-disturbed patients in his own home - the Vineyards - since the 1760s. An advertisement in the Morning Chronicle for 26 January 1793 claimed that he had:¹³

for thirty years past had patients under his care afflicted with this melancholy disorder, most of whom have been sent home to their friends in a sound state of mind.

Although no record of these earlier patients exists, an account book for Ticehurst Asylum begun in 1792 has 'New House Book' on the cover, as though to differentiate it from an 'old house'.¹⁴

In the absence of alternative information, it seems plausible to suggest that Samuel Newington may have decided to extend his practice as a mad-doctor in order to provide employment and income for his children as they entered adulthood.¹⁵ The death of his own father in 1790 may have provided him with the capital necessary to do so. Samuel and Martha Playsted had ten sons and five daughters, only one of whom died in infancy (see Newington Family Tree II). Early account books show that payments were sometimes made to Joseph, Zebulon, George and John Newington, as well as to Samuel. When Samuel went to collect patients to bring them to the asylum, he

was sometimes accompanied by one of his sons, or in the case of female patients, by one of his daughters.¹⁶

Four of Samuel and Martha's sons eventually qualified as surgeons. The eldest, Samuel Playsted, practised in nearby Goudhurst in Kent. Zebulon moved to Spitalfields in London. Jesse and Charles assisted their father until his death in 1811, when they took over the running of Ticehurst Asylum.¹⁷

The building which housed the new asylum probably was not purpose-built. Early advertisements refer to the house having been 'fitted up and neatly furnished' rather than built.¹⁸ The earliest reference which I have been able to find to Samuel Newington having 'erected' the building is in a biography of his son Charles, in M.A.Lower's *Worthies of Sussex*, published in 1865.¹⁹ Ground-plans of the asylum which appeared in a prospectus in 1828, before alterations were made to the main building by Charles, suggest the lay-out of a country mansion, with no system of classification, or special provision for the most violent and refractory patients, such as was found in the purpose-built private asylum of Brislington House.²⁰

Throughout June and July in 1792, regular advertisements appeared in the Sussex Weekly Advertiser for the new asylum, which (it was announced in mid-July) would be

ready on 1 August.²¹ In fact the first patient, a Mr James Bigg, was admitted on 23 July. Despite continuing advertisements, admissions came slowly at first. By Christmas, only six patients had been admitted, and only four were resident in the asylum.²³

Fees fell within the middle range of those charged by private-madhouse proprietors. The first patients at Ticehurst paid one guinea a week, inclusive of washing and medicines.²⁴ This was significantly more than, say, the £30 a year plus a two-guinea entrance fee, charged in 1787 by a Mr Stroud in Staffordshire, but considerably less than the four guineas a week which Dr Francis Willis boasted he charged patients at his private madhouse in Lincolnshire in 1788.²⁵ It would make Ticehurst comparable to the Islington madhouse where Charles Lamb's sister Mary was confined after stabbing her mother in 1796, where fees started at around £50 a year; or to the private madhouse run by Thomas Burman in Henley-in-Arden, who explained in 1795:²⁶

My general terms are one guinea/week for board and medecines, the patient finding their own linen and washing. If any person chuses a servant constantly to attend on them, board and wages are separately considered.

Similarly at Ticehurst, the first patient to pay more than one guinea a week, a Mr Daniel Lintall, who was admitted on 5 November 1792, paid board and wages for a servant, in addition to two guineas a week, exclusive of

washing and medicines.²⁷ Presumably, like Mary Lamb, who paid more than £50 a year, but had a room as well as a servant to herself, Daniel Lintall enjoyed a higher standard of accommodation than could be obtained at Ticehurst for one guinea a week.²⁸

As well as offering competitive prices, Samuel Newington needed to generate confidence in the quality of care he was offering at Ticehurst. Despite sluggish admissions, advertisements suggest he favoured a selective admissions policy. In January 1793 he wrote:²⁹

The house has an attic storey, and contains many neat apartments; is rendered perfectly safe and so contrived as to admit of every convenience requisite for the reception of patients who do not require strict confinement.

Mr Newington begs leave to inform his friends that he does not wish to receive into his house any patients but such as are of a quiet and tractable disposition, as the comfort and convenience of all his Patients are what he means particularly to attend to, and, therefore, if any offer of a more violent turn, that such will be suitably provided for in his neighbourhood until by his management they become more tractable and proper to be received among those of the above description.

Simultaneously, Ticehurst was represented here as exclusive, and protected from the worst extremes of madness; whilst Samuel Newington's capabilities in dealing with the insane were promoted.

In the first half of 1793 the admissions rate doubled, so

that twelve more patients had been admitted by the end of June. After that, it remained at a similar level for the next four years (see Table 1). The number of patients in the asylum rose by July 1795 to around sixteen, with more men than women generally resident in the asylum (see Table 2).

At first, the policy of excluding violent and intractable patients was put into practice. In July 1793, the first patient to be charged in the accounts for the repair of broken windows was temporarily removed to a Mr Badcock's. With the onset of winter in October 1794, Samuel Sands 'Was carried to St Luke's having been here 22 weeks, about three months out of the House'. In March 1795, a patient called Thomas Avan was also transferred to St Luke's Hospital in London after breaking windows.³⁰

At the same time another, higher-class patient, Revd Richard Podmore, the vicar of Cranbrook in Kent, only seven miles from Ticehurst, remained in the asylum after breaking windows.³¹ Thereafter, other patients who behaved in a similar way were allowed to stay.³² Only one other patient appears to have been boarded out: in July 1801 a Mrs Shrivell was boarded for four months with a Widow Skinner, having already spent four months in the asylum. The reasons for her seclusion are not known, although since for the last three weeks of her

confinement she paid for the upkeep of a child as well as herself, it seems possible that this was a case of insanity during pregnancy.³³

The nature of treatment offered in late eighteenth-century lunatic asylums has been the subject of recent debate amongst historians. Traditionally, two changes were seen as marking a radical shift from what were regarded as the standard practices of eighteenth-century 'psychiatry'; that is, mechanical restraint and medical, generally depletive, therapeutics. Firstly, the symbolic freeing of lunatics from their chains by Philippe Pinel (1745-1826) at the Bicetre in revolutionary Paris; and secondly, the abandonment of medical treatment at the Retreat in York, in favour of management through emotional persuasion, or what came to be known as 'moral' treatment.³⁴ As William Bynum has argued, what was distinctive about moral therapy was not its direct appeal to the patient's mind, which had equally been the object of the more intimidating methods used by eighteenth-century mad-doctors (such as beatings and starvation), but rather its emphasis on the importance of 'kindness, reason and tactful manipulation' - on persuasion rather than coercion.³⁵

More recently, Roy Porter has challenged the notion of a radical shift between late-eighteenth and

early-nineteenth century treatment of the insane, arguing that many of the tenets of moral treatment are present in eighteenth-century texts, and (although the evidence for this is more tentative) formed part of eighteenth-century practice. Ticehurst is one of the asylums he cites as offering relatively benign treatment to an affluent and exacting clientele. Yet the plausibility of his argument that:

It would be surprising if the kind of clientele that was seeking such 'health-farm' conditions for its mad relations would have tolerated maltreatment from the proprietor and his staff.

is less common-sense than it appears, since what constitutes 'maltreatment' is clearly historically relative.³⁶ Notoriously, even King George III was chained-up, beaten and starved during his illness of 1788-9, with the (albeit reluctant) consent of his relations.³⁷

In a paper which seeks to contextualize the way in which moral treatment in the early-nineteenth century may have represented a real change from eighteenth-century methods of treatment, Andrew Scull has argued that the chainings and beatings which seem inhumane from a modern perspective, seemed appropriate to an eighteenth-century world view which saw insanity as a loss of the only capacity which distinguished human beings from animals - that is reason.³⁸ Although details of treatment which

can be gleaned from the account books at Ticehurst are necessarily fragmented, even the solitary example of Samuel Sands being kept outside for three months - perhaps in an outhouse or barn, since the accounts show clearly when patients were boarded out with local people - suggests that some of the same thinking which informed what were by 1815 to be regarded as the worst abuses of the private asylum system, also informed practices at Ticehurst.³⁹ However, there is no evidence to suggest that patients at Ticehurst were subjected to the kind of systematic neglect reported by the Commons select committee of 1815-16; nor that the harshest treatment was reserved for pauper patients.⁴⁰ (A small, but slightly increasing percentage of admissions to Ticehurst before 1817 were paupers: see Table 3.1).

The extent to which mechanical restraint was used at Ticehurst is unclear. For the first few years, the boarding-out of violent and refractory patients may have made the restraint of patients in the asylum uncommon. In 1801, a patient was billed 7s.7d. for a 'straight waistcoat', but this could have been to replace one which he had damaged, or because he or his family wanted him to have one of his own, rather than meaning that this was the only occasion on which mechanical restraint was used.⁴¹ Although a selective admissions policy may have kept the number of violent patients to a minimum, the

frequent charges for the repair of broken windows, and in one case for the replacement of a broken chamber-pot, suggest both that there were patients whose behaviour needed restrained, and that such restraint was not habitual.⁴²

Equally, the nature and frequency of medical treatment is unclear. That 'medicines' were at first included in a fixed charge along with board and washing suggests that their routine use was anticipated. However, later entries only rarely specify whether washing and 'wine', rather than 'medicines', were included or excluded, and patients were sometimes charged separately for both.⁴³ Wine may have been prescribed as part of a stimulating diet in cases of melancholia; unfortunately where 'medicines' were charged for separately, they were not itemized.⁴⁴ The normal use of depleting medicines and methods of treatment, such as bleeding, to control states of mania might indirectly explain why a pregnant patient like Mrs Shrivell was, unusually, boarded out: late-eighteenth and early-nineteenth century texts on midwifery advise against using severe depleting medicines on pregnant women, even in states of acute mania.⁴⁵

On the other hand, Samuel Newington's emphasis on 'management' in advertisements for Ticehurst suggests that he did not rely exclusively on medical treatment.

Indeed, his concern with the 'comfort and convenience' of his patients would place him within the tradition of eighteenth-century asylum proprietors whose desire to create a 'civilised and calming environment' has been taken by Roy Porter as evidence of moral therapeutic objectives in practice before the influence of Pinel and Samuel Tuke.⁴⁶ There is ample evidence that care was taken at Ticehurst to foster patients' feelings of self-esteem: regular payments for shaving, hairdressing, and new items of clothing record the attention paid to patients' dress and appearance.⁴⁷ In addition, some patients were allowed extras - like pipes, tobacco and snuff, as well as cheese, gingerbread, liquorice, oranges, sugar-candy and wine - which suggest a liberal regimen.⁴⁸

Extensive freedoms were enjoyed by some patients, particularly those paying higher fees. Thus the extras Daniel Lintall paid for in 1794-5 included fishing-tackle, gun-cleaning, and the keep of his horse and dog.⁴⁹ The image this conjures up of patients who, despite their insanity, pursued the normal leisure activities of the English squirearchy is a leitmotif of Ticehurst's history. Yet even if these activities were encouraged because they were believed to have therapeutic effects, it is unclear how far this might be because the principles which informed treatment at Ticehurst were

'moral'. Even Samuel Tuke lists exercise as part of both medical and moral treatment.⁵⁰

In many respects, the treatment offered at Ticehurst is reminiscent of what is known of Francis Willis' methods of treatment, both of King George III and in his private madhouse in Lincolnshire. The desire to test a patient's returning self-control with increased freedom and exposure to risk was evident in Willis' treatment of King George III when he allowed the king access to a razor and pen-knife to shave and cut his nails.⁵¹ If Daniel Lintall was permitted to ride and to use his gun whilst he was at Ticehurst, similar thinking may have informed the decision. Exercise formed a central part of the regime at Greatford. A visitor to the asylum in 1796 commented that:⁵²

As the unprepared traveller approached the town, he was astonished to find almost all the surrounding ploughmen, gardeners, threshers, thatchers and other labourers attired in blackcoats, white waistcoats, black silk breeches and stockings, and the head of each 'bien poudre, fris   et arrang  '. These were the doctor's patients, and dress, neatness of person, and exercise being the principal features of his admirable system, health and cheerfulness conjoined to aid recovery of every person attached to that most valuable asylum.

Although there is no evidence that patients at Ticehurst were employed, the regular attention paid to patients' appearance, as well as payments for shoe-mending, fishing-tackle and horse-keep, suggest the same kind of

priorities.⁵³ In addition, rational mental recreations were permitted: thus Daniel Lintall's other purchases included the 'Beauties of Stern', 'Speaker Endfield's' and 'Magazines'.⁵⁴ In a similar spirit, during King George III's lucid intervals, Francis Willis conversed and played backgammon with him.⁵⁵ Other activities patients at Ticehurst engaged in included spinning and sewing, playing the harpsichord and violin, drawing and writing.⁵⁶

In other respects, the account books suggest differences between the asylum and the outside world were kept to a minimum. Apart from the musical instruments above, some patients bought items of furniture, such as a sofa or writing-desk, which suggest the Newingtons tried to establish as domestic and everyday an environment as possible.⁵⁷ One patient even bought a bird-cage, and presumably kept pet birds in his room at the asylum.⁵⁸ More importantly, another patient came accompanied by his mother, who stayed with him in the asylum; and two female patients brought their own maid-servants with them.⁵⁹ Regular charges for writing-paper and postage imply that patients were not discouraged from communicating with their friends and relations.⁶⁰

From all of these activities it is possible to infer that attempts were made at Ticehurst to solicit patients'

'rationality, self-restraint and self-esteem' - the qualities which Roy Porter has emphasized as central goals of moral therapy. He is right to identify the advocacy of this kind of treatment as evidence of a tradition of moral therapeutic ideas in 'psychiatric' thought before the publication of Samuel Tuke's Description of the Retreat (1813).⁶¹

Fragmented as the evidence of therapeutic practice at Ticehurst is for this early period, it clearly included non-medical and non-mechanical elements. However, there is insufficient evidence to assess how readily mechanical restraint was resorted to; whether medical treatment was directed at mental disorders as well as intercurrent physical derangement; and how far psychological management was effected through fear rather than through kindness. The close parallels between what is known of treatment at Ticehurst and some of the more genial practices of Francis Willis - whose less sympathetic treatment of King George III has been taken as the archetype of what William Bynum has described ironically as 'immoral therapy' - suggest how continuous the spectrum between moral and medical/mechanical therapy may have been in practice, especially in middle and upper-class asylums.⁶²

It seems important to stress the value which high

standards of physical care and attention to patients' appearance could have in reassuring a prospective clientele. Excluding violent and destructive patients from Ticehurst, and maintaining an appearance of normalcy by engaging patients in ordinary activities could serve a similar function. Claims that Francis Willis and others could calm patients with an authoritative look reflect how crucial it was for asylum proprietors to assume an almost magical competence in dealing with patients whose behaviour caused friends and relations to feel helpless.⁶³

From the patient's perspective, the benefits of this increased attention could be less self-evident. Rather than enhancing his self-esteem, John Perceval experienced routine shaving and nail-cutting at Brislington House in the early 1830s as an indignity and assault on his individuality; although he also complained that he was shaved only three times a week, and not every day.⁶⁴ In contrast, although retrospectively humiliated to have been put in such a situation, he recalled the two weeks he spent chained up in an outhouse on a bed of straw as a relatively happy period:⁶⁵

Here there was comparative peace, seclusion, freedom from intrusion. Here I had no servant sleeping in the room with me. Here I might hollo or sing as my spirits commanded ... and although my right arm was fastened by a short chain to the wall and the strap pressed rather tightly across my chest, it was still something to

have one arm free even in the straight waistcoat, and not to be galled by the fastening on the other.

Whatever the exact nature of treatment offered at Ticehurst, the formula was a successful one, and during the first twenty-five years admissions rose steadily (see Table 3). By 1815, the asylum had more than doubled its population in 1795 (see Table 4). The connections between Ticehurst and the kind of therapy offered by the Willises are underpinned by the fact that three patients came to Ticehurst via the Willis family. In February 1797, a Revd Chambers was referred to Ticehurst by Dr Robert Darling Willis in London.⁶⁶ Another patient, a Revd Lofty from Canterbury was accompanied from Dr Willis' in Lincolnshire to Ticehurst in December 1799, although it is unclear whether he had been a patient at Greatford, or travelled all the way to Lincolnshire - a return journey of six days - to consult Francis Willis. Equally, since attendance was charged only to and from Barton, it is not certain whether whoever accompanied Revd Lofty to Ticehurst actually visited the asylum at Greatford themselves.⁶⁷ In 1808, a Mr Darnay was transferred to Ticehurst from Greatford.⁶⁸

However, it is worth stressing that patients such as these, who paid above-average fees of two to three guineas a week, and enjoyed the kind of extra privileges

Figure 1: Fees Charged to First Admissions, 1792 - 1817

Fees rounded to nearest half-guinea; years run 1 August - 31 July.

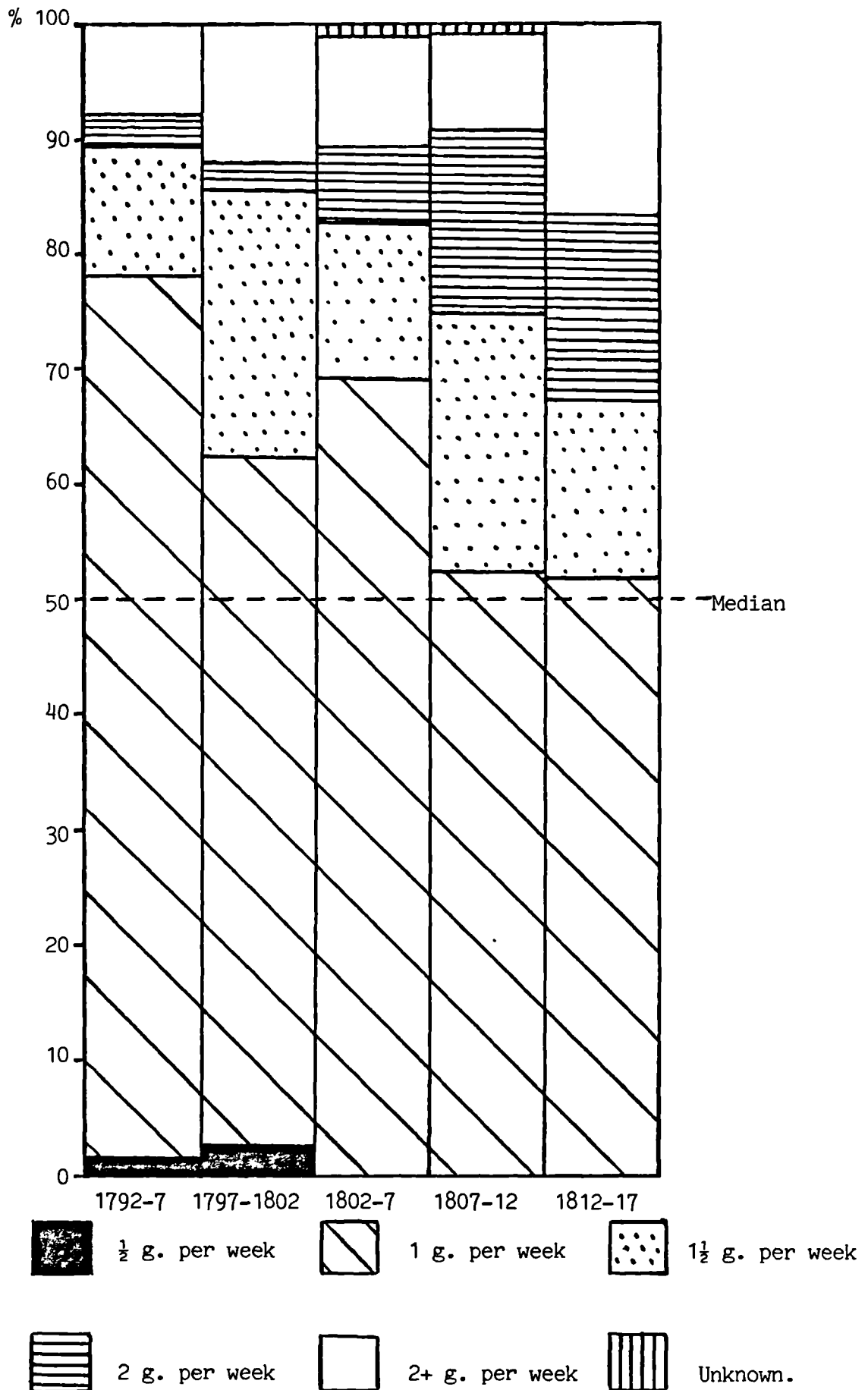


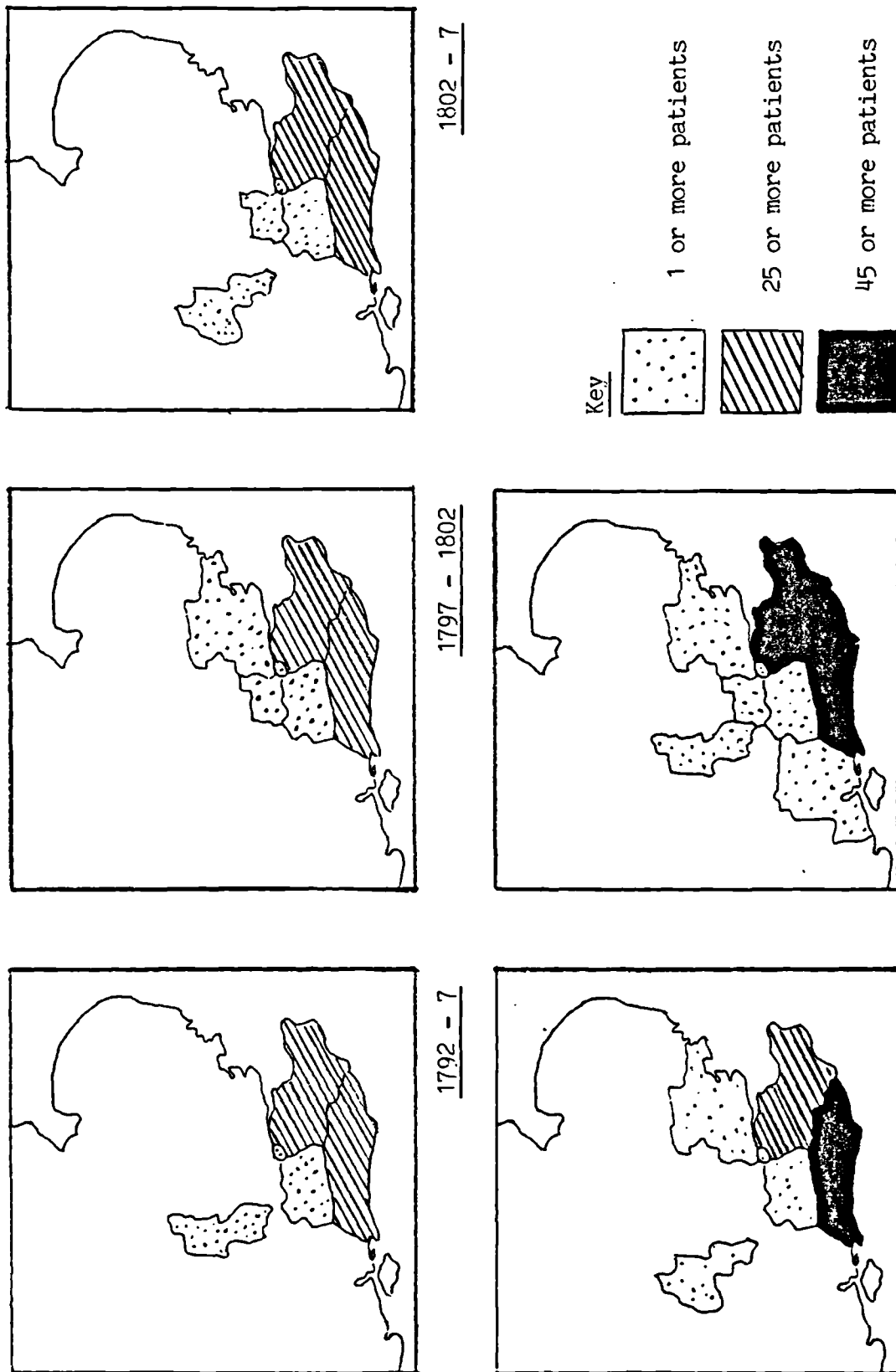
Figure 2 : Home Counties of First Admissions to Ticehurst, 1792 - 1817



described above, represent the upper end of Ticehurst's market.⁶⁹ Despite war-time inflation, and a gradual increase in the percentage of patients paying higher fees, the median charge for first admissions to Ticehurst remained one guinea a week (see Figure 1). The former occupations, or social class, of patients is known for only nineteen male and three female admissions before 1815, apart from those described as paupers. Of these, all three women, and two men, were described as 'independent'. There were eleven clergymen, one admiral, one captain, one merchant, one surgeon-apothecary, one druggist, and one clerk from India House.⁷⁰ Since all except two of these (the captain and one of the female patients) paid more than the average one guinea a week, it seems reasonable to assume that the majority of Ticehurst's inmates during this period came from the lower professional and commercial middle class, and the families of moderately prosperous tenant farmers, rather than the haute bourgeoisie and gentry who formed the Willises' clientele.⁷¹

The vast majority of first admissions to Ticehurst during the first twenty-five years the asylum was open came from Sussex or Kent (see Figure 2). An analysis of these admissions over time suggests a gradually expanding and consolidating reputation throughout south-east England, but with admissions heavily concentrated in Sussex and

Figure 3 : Home Counties of First Admissions to Ticehurst, in five-year periods, 1792 - 1817



Years run from 1 August - 31 July.

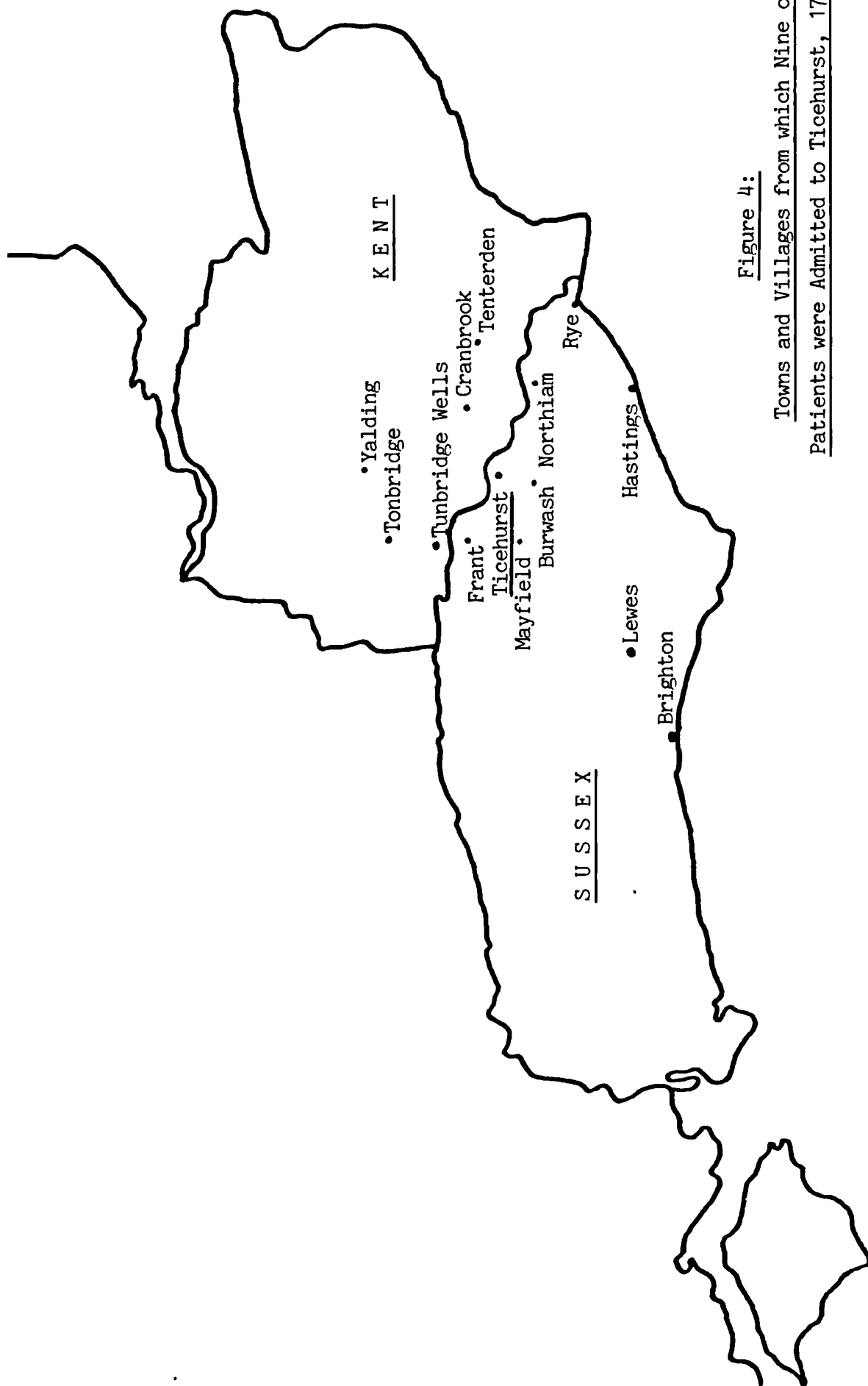


Figure 4:

Towns and Villages from which Nine or More
Patients were Admitted to Ticehurst, 1792 - 1817

Kent (see Figure 3). Indeed, the country parishes which sent most patients to Ticehurst clustered within a thirteen-mile radius of the asylum. Patients travelled further from the commercial (and except Rye, larger) centres of Brighton, Hastings, Lewes and Rye (see Figure 4).

However, no close connection exists between the size of the towns and villages sending most patients to Ticehurst, and the number of patients they sent (see Table 6). The percentage of the population these admissions represented was far greater for rural parishes than in the towns. To take two extremes, the proportion of the population of Frant admitted to Ticehurst was ten times the same proportion for Brighton. Nor can this be explained by greater distance alone: the proportion of admissions from Tunbridge, twelve miles from Ticehurst, was far lower than admissions from Tenterden or Yalding, both thirteen miles away. The evidence from Ticehurst would therefore lend no support to the hypothesis that there was a simple correlation between living in larger centres of population, and a preference for institutional solutions.

How unusual it was for lunatics to be cared for in asylums in Kent and Sussex during this period remains obscure. Pauper lunatics may more frequently have been

cared for in workhouses, or boarded out individually, than admitted to private asylums. An 1819 return of the number of lunatics confined in licensed houses in England, lists only two small private asylums in Kent, at West Malling and Blackheath, containing eleven and seven patients respectively. However, such statistics need to be treated with caution, since the same return claims that there was 'No Licensed House within the County of Sussex', listing Ticehurst in error as a county asylum.⁷²

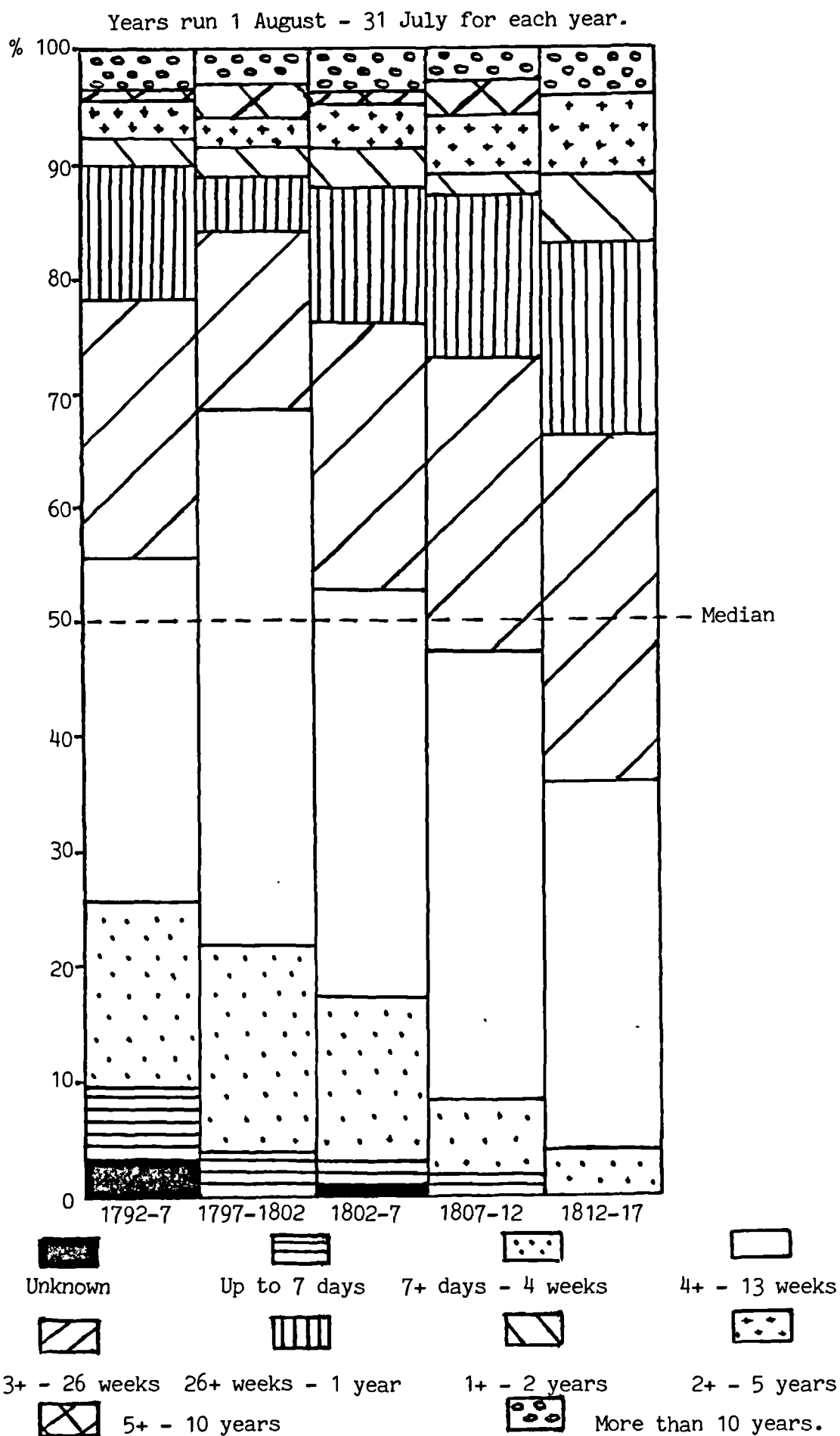
There is some evidence suggesting that a resort to institutional solutions may have been linked to social stress. Thus a higher proportion of the population of Hastings, which was expanding exceptionally rapidly during this period, were admitted to Ticehurst than from other towns.⁷³ The 1811 census showed the population of Yalding (or Yalden) to have larger than average families - of six or seven members rather than four or five - and a disproportionate number of patients admitted to Ticehurst from Yalding were paupers (five out of eleven, compared with two from Burwash, and one from each of Lewes, Mayfield and Rye).⁷⁴

Another local factor which could possibly have influenced the number of patients referred to Ticehurst was the presence of a local doctor sympathetic to asylum methods of treatment, or personally and/or professionally

supportive of the Newingtons. Evidence of who the referring doctors were survives for those patients admitted between 6 April 1802 and 23 December 1812 whose admission was recorded in the Country Register.⁷⁵ These represent only slightly over one third of admissions recorded in the accounts of the asylum (including re-admissions).⁷⁶ A further seven patients who were still resident in 1828 had the names of their certifying doctor recorded in a register of patients which was opened then.⁷⁷ Five doctors certified three or more of these 104 patients: Thomas Bishop, a surgeon from Tenterden (3); Charles Crouch, a surgeon from Hastings (3); Samuel Newington from Goudhurst (3); Robert Watts, M.D., from Cranbrook (9); and Robert Montague Wilmot, M.D., from Hawkhurst in Kent (3). Of these, only Samuel Newington is known to have had a close connection with Ticehurst, although after 1812 Robert Watts sometimes acted as a consultant physician to the asylum.⁷⁸

There is no evidence (apart from the breaking of windows at Ticehurst) of the kind of behaviour which may have led to certification. One patient is known to have been epileptic.⁷⁹ Of those patients who were still resident in the asylum in 1842 when a register of patients listed diagnoses, seven were described as suffering from 'imbecility' or 'amentia', and one woman as subject to 'delusions'.⁸⁰ The Country Register listed the name of

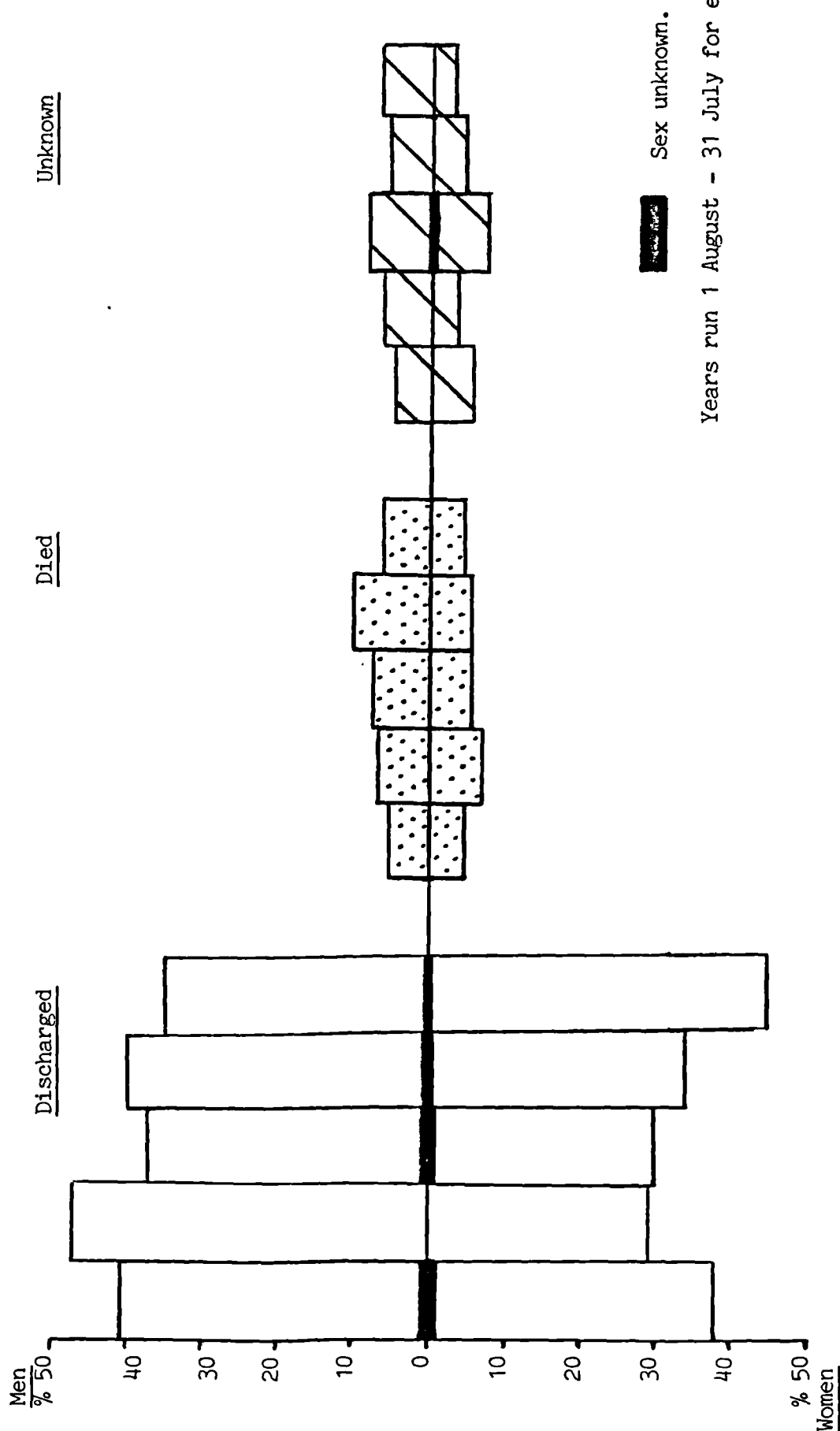
Figure 5: Length of Stay of First Admissions, 1792 - 1817



the family member or friend by whose direction the patient was confined, although the exact relationship was only rarely listed; in addition, there is information on who authorized the confinement of eight other patients who were still resident in 1828 (see Table 7). As might be expected, it is clear that most patients were admitted under the authority of at least one family member. It is also noticeable that more men than women authorized confinement, although more male than female patients had their confinement authorized by women. This would suggest that women generally only signed certificates when a close male relative who would normally undertake such legal responsibilities, like a husband or son, was being certified.⁸¹

The length of time new admissions spent in the asylum increased gradually during the first twenty-five years, from a median of between one and three months to between three and six months (see Figure 5). Less than fifteen per cent of new admissions spent more than one year in the asylum. Whilst this suggests a rapid turnover of patients, some of the earliest admissions became very long-stay. Thus John Daniel Lucadon, admitted on 20 July 1793 was resident in the asylum for almost sixty-one years, until his death on 26 June 1854; and Revd Chambers, confined on 18 February 1797, was a patient for over thirty-seven years before his discharge on 24 June

Figure 6: Outcome of Stay for First Admissions to Ticehurst, in Five-Year Periods, 1792 - 1817



1834.⁸² These patients gradually accumulated, so that by 31 July 1815 almost one third of the patients resident in Ticehurst had a total length of stay of more than twenty years. When patients are looked at in profile, the median length of stay increased from between one and two years on 31 July 1795 to between five and ten years on 31 July 1800: a level at which it remained until 31 July 1815 (see Table 8).

The median length of stay for new male admissions was slightly longer than for new female ones (see Table 9). Looked at in profile, the difference in length of stay between male and female patients is even more pronounced (see Table 8.1). Although a slighter higher proportion of female than male patients were re-admitted, some of whose admissions extended over a total period of more than five years, more than two-thirds of those admissions who stayed more than five years continuously in the asylum were men (see Table 9).⁸³

Seventy-six per cent of first admissions to Ticehurst during this period are known to have been discharged (409 patients), and thirteen per cent to have died in the asylum (70 patients). The outcome of treatment for the remaining eleven per cent is unknown (59 patients). The death-rate for men was slightly higher than for women (see Figure 6). The condition of those who were

discharged was rarely recorded, although occasionally a patient was listed as having gone home 'well' or 'cured'. Those whose state of mind at discharge was recorded are shown on Table 10. Fourteen patients are known to have been transferred to other asylums: ten to St Luke's, two to Bedlam, one to Fisher House, and one to Holly House in Hoxton.⁸⁴

Not surprisingly, the pattern of discharge and death is significantly different when the patient population is looked at in profile. By 31 July 1800, almost two-thirds of the patients who were resident in Ticehurst would eventually die in the asylum. The numbers are too small for percentages, but the ratio of deaths to discharge remained around 2:1 until 31 July 1815, when it dropped to 1:1 (see Table 11).

Although only one patient in eight was described as having been 'well' when they left Ticehurst, there is other evidence which would suggest satisfaction on the part of the Newingtons' clients, and the full recovery of some patients. Thus when a Miss Baker left the asylum in May 1794, in addition to paying her bill she spent eleven guineas on 'Presents to our [the Newington] family', presumably in gratitude for the treatment she had received.⁸⁵ Revd William Courthope (1768-1847), who was a patient from November 1798 - January 1799, went on to

become chaplain to the Earl of Chichester, vicar of Brenchley in Kent (1802-47), and rector of St John's, Southover, in Lewes (1805-21).⁸⁶

Financially too the asylum was successful. Although the median cost for first admissions remained at one guinea per week, the median charge for patients resident in the asylum rose to two guineas per week by 31 July 1810 (see Table 5). Since the number of patients resident in the asylum also doubled, the Newingtons' income quadrupled between 31 July 1795 and 31 July 1815. Even allowing for the increase in expenditure necessitated by war-time inflation, this would suggest an increase in income in real terms of around 100%.⁸⁷

On 8 July 1811, Samuel Newington died.⁸⁸ Although the two sons who succeeded him, Charles and Jesse, were both qualified as surgeons, from 1812 the accounts show that outside medical advice was sometimes consulted, notably from Dr Robert Watts in Cranbrook, and Dr John Mayo (1761-1818) in Tunbridge Wells.⁸⁹ In 1812, Charles married Eliza Hayes, the daughter of a former canon of St Pauls, and built a new house for his future family, the Highlands.⁹⁰ Perhaps emulating the varied walks advocated as therapeutic by Samuel Tuke in 1813, Charles and Jesse employed men who had been demobilized after the battle of Waterloo to landscape and ornament over forty

acres of grounds in 1816.⁹¹ Over two miles of footpaths led through the plantations, orchard and gardens, past summer houses (one of which was fashionably gothic), a pheasantry, an aviary of singing birds, a moss-house, a pagoda, a hermitage and a bowling green.⁹² The accounts from this period of post-war deflation suggest a new financial confidence. Thus in February 1816, when a Mr Pilgrim was '... too poor to pay as he ought for every kindness shewn to his daughter', £11 12s was deducted from the bill; in April 1817, when a Mrs Whitehead could not afford to pay her bill, the Newingtons 'gave the poor woman' two guineas.⁹³

It is unclear how far the accumulation of high fee-paying, long-stay, mostly male patients represented an intentional and mercenary policy on the part of the Newingtons: their increasing charity to poorer patients counts against this interpretation.⁹⁴ It seems equally likely that relatives who could afford it might have offered higher fees for long-stay patients, hoping that this would guarantee a continuing adequate degree of care. Some long-stay patients paid increased fees which kept step with inflation to maintain standards of treatment. Only one eventually decreased his fees, presumably because his family was unable to support the continuing financial burden.⁹⁵ In December 1821 a patient who had been admitted in February 1817 left the

asylum when her husband became bankrupt, and her last bill was not paid until 1826.⁹⁶

Nevertheless, long-stay patients guaranteed a core income for the Newingtons, whilst their relationships with local, and in the case of John Mayo, prestigious physicians ensured the patronage which would bring higher-class patients to the asylum. The newly landscaped grounds revealed the younger Newingtons' social aspirations as well as a fashionable adherence to contemporary modes of treatment. High standards of physical accommodation and care underpinned their reputation. During its first twenty-five years, the foundations of the asylum's future success had been securely laid.

NOTES: CHAPTER 1

1. For the impact of industrialization and urbanization on the family, see Harold Perkin, The Origins of Modern English Society, 1780-1880, (London: Routledge & Kegan Paul, 1969), pp.149-60; for their impact on mental health policy, see David Mechanic, Mental Health and Social Policy, (Englewood Cliff, N.J.: Prentice Hall, 1969), p.54. Both Richard Hunter and Ida Macalpine, George III and the Mad Business, (London: Allen Lane, 1969), p.322, and William Ll. Parry-Jones, The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries, (London: Routledge & Kegan Paul, 1972), pp.1 & 13 cite the impact of industrialization in creating a reservoir of inadequately cared for pauper lunatics.
2. Andrew T. Scull Museums of Madness. The Social Organization of Insanity in Nineteenth-Century England, (London: Allen Lane, 1979), pp.27-9.
3. Richard Hunter and Ida Macalpine, op.cit. note 1, pp.329-33.
4. Charles Seymour, A Topographical, Historical and Commercial Survey of the Cities, Towns and Villages of the County of Kent, arranged in Alphabetical Order, (Canterbury: for the author, 1776), p.552.
5. William Perfect's Methods of Cure, in Some Particular Cases of Insanity, the Epilepsy, Hypochondriacal Affections, Hysteric Passions and Nervous Disorders, (Rochester: T.Fisher, for the author, 1778), went through seven editions under various titles; the final edition appeared as Annals of Insanity, (London: for the author, 1809) in the year of his death. In addition, he published A Remarkable Case of Madness, with the Diet and Medicines Used in the Cure, (Rochester: for the author, 1791). (See Richard Hunter and Ida Macalpine, Three Hundred Years of Psychiatry, 1535-1860, (London: Oxford University Press, 1963), pp.500-1).
6. Sussex Weekly Advertiser, 26 November 1792, vol.46 no.2414.
7. Peter J. Neville Havins, The Spas of England, (London: Hale, 1976), pp.22-4; see also Noel G. Coley, '"Cures without Care", "Chymical Physicians" and Mineral Waters in Seventeenth-Century English Medicine', Medical History, 23 no.2 (1979),

pp.191-214.

8. William Perfect, op.cit. note 5, (1778), pp.64-5.
9. Peter J. Neville Havins, op.cit. note 7, pp.25 & 124-5; Richard Hunter & Ida Macalpine, op.cit. note 1, pp.3-13; Margaret Barton, Tunbridge Wells, (London: Faber & Faber, 1937), p.310.
10. Edward Long Fox and William Tuke were both Quakers. The former ran a small private madhouse at Cleeve Hill, Downend, near Bristol, from 1794-1806, before opening Brislington House, a large and expensive institution which rivalled Ticehurst in the early - mid-nineteenth century (see William Ll. Parry-Jones, op.cit. note 1, pp.112-5); William Tuke was founder of the Retreat in York (see Richard Hunter and Ida Macalpine, op.cit. note 5, p.684).
11. For a family tree, see William Berry, Pedigrees of the Families in the County of Sussex, (London: Sherwood, Gilbert & Piper, 1830), pp.158-60.
12. Medical Register (1779), pp.93-4 & 136.
13. Quoted in Leonard James Hodson and Julia Odell, Ticehurst: The Story of a Sussex Parish, (Tunbridge Wells: "Courier" Co., 1925), p.148.
14. Bill Book, 1792-1802.
15. William Ll. Parry-Jones discusses Francis Willis' desire to leave 'an accustom'd house for wrongheads' as a lucrative bequest for his sons (op.cit. note 1, p.75).
16. For example, references to George and Joseph Newington, Bill Book, 1792-1802, pp.52 & 79; references to Zebulon and John Newington, ibid., 1802-11, pp.10 & 97. Samuel Newington travelled to Deal in Kent with one of his daughters to collect Mrs Hester Blomer in October 1800; and to Hackney with one of his sons to collect Revd Newcomb (ibid., 1792-1802, pp.78 & 88).
17. I could find no details of Samuel Playsted's qualifications: he is described as a "surgeon" in the Country Register, and signed certificates for four admissions to Ticehurst (MH51/735 79595, pp.63, 64 & 121). Zebulon is listed as a member of the Royal College of Surgeons in 1805, living in Bishopsgate (A List of the Members of the Royal College of Surgeons in London, Who Reside and Practise, or Who Have Heretofore Resided and

Practised in or within Seven Miles of the City of London, (London: J.Adlard, 1805), p. 15). Jesse and Charles are also both listed as members of the Royal College of Surgeons in 1805 (A List of the Members of the Royal College of Surgeons in London, Who Do Not Reside or Practise in or within Seven Miles of the City of London, (London: J.Adlard, 1805), p.54). The Medical Directory for 1847 gives Charles' qualifying date as 1802.

18. Leonard James Hodson and Julia Odell, loc.cit. note 13.
19. M.A. Lower, The Worthies of Sussex: Biographical Sketches of the Most Eminent Natives or Inhabitants of the County, from the Earliest Period to the Present Time, (Lewes: printed for subscribers only by G.P.Bacon, 1865), p.254.
20. Ticehurst Private Asylum for Insane Persons, (place of publication unknown, c.1828), last three pages. For a description of Brislington House see William Ll. Parry-Jones, op.cit. note 1, pp.112-5.
21. Sussex Weekly Advertiser, 18 June - 30 July 1792, vol.46 no.2391-6.
22. Bill Book, 1792-1802, p.2.
23. Sussex Weekly Advertiser 7 August - 24 December 1792, vol. 46 nos. 2397-418. Bill Book, 1792-1802, pp.1-6.
24. ibid., 1792-1802, *passim*; see also Figure 1.
25. William Ll. Parry-Jones, op.cit. note 1, p.124; Richard Hunter and Ida Macalpine, op.cit. note 1, p.71.
26. William Ll. Parry-Jones, op.cit. note 1, pp.124-5.
27. Bill Book, 1792-1802, p.5.
28. Letter from Charles Lamb to Samuel Taylor Coleridge, 3 October 1796, in "E.R." (ed.), The Letters of Charles Lamb, (London: Everyman, 1909), p.38.
29. Quoted in Leonard James Hodson and Julia Odell, loc.cit. note 13.
30. Bill Book, 1792-1802, pp.4, 21 & 19.
31. Richard Podmore (b.1744). Son of Richard Podmore, cleric. Educated at Shrewsbury School and Christ's

College, Cambridge. Vicar of Cranbrook, Appledore and Ebony St Mary from 1777. (Alumni Cantab.). He was a patient at Ticehurst, 8 September 1794 - 17 March 1796, at a cost of £1.11s.6d. per week (Bill Book, 1792-1802, p.26).

32. For example, Elizabeth Latter in July 1795, and Revd Chambers in June 1799 (ibid., pp. 35 & 49).
33. ibid., p.83.
34. See, for example: E.T. Carlson and Norman Dain, 'The Psychotherapy that was Moral Treatment', American Journal of Psychiatry, 117 (1960), pp.519-24; E.T. Carlson and E.A. Woods, 'The Psychiatry of Philippe Pinel', Bulletin of the History of Medicine, 35 (1961), pp. 14-25; K.Gränge, 'Pinel and Eighteenth Century Psychiatry', ibid., pp.442-53; J.S.Bockoven, Moral Treatment in American Psychiatry, (New York: Springer Pub. Co., 1963), pp.12-16; Norman Dain, Concepts of Insanity in the U.S.A., 1789-1965, (New Brunswick, N.J.: Rutgers University Press, 1964), p.12; Aubrey Lewis, The State of Psychiatry, (London: Routledge & Kegan Paul, 1967), p.7; E.H. Ackerknecht, A Short History of Psychiatry, (New York: Hafner Pub. Co., 1968), p.40.
35. William F. Bynum, 'Rationales for Therapy in British Psychiatry, 1780-1835', Medical History, 18 (1974), pp.318-9.
36. Roy Porter, 'Was there a Moral Therapy in Eighteenth-Century Psychiatry?' Lychnos, (1981-2), pp.12-16; quote taken from page 15. For a discussion of changing perceptions of cruelty in relation to moral treatment, see Andrew T. Scull, 'Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry', Psychological Medicine, 9 (1979), pp.421-8.
37. See, for example: William F. Bynum, op.cit. note 35, p.319; Richard Hunter and Ida Macalpine, op.cit. in note 1, document in detail the conflicting attitudes of the family and friends who surrounded King George III to his treatment by the Willises.
38. Andrew T. Scull, op.cit. note 36, pp.423-4; see also William F. Bynum, op.cit. note 35, p.320.
39. For Samuel Sands, see note 30; Report from the Committee on Madhouses in England, July 1815, (PP1814-15(296.)IV.801-), pp.4 & 6.

40. The worst private asylum conditions reported in the 1815-16 Select Committee Report were in those which took large numbers of pauper lunatics, most notably Thomas Warburton's Red and White Houses in Bethnal Green (Report from the Select Committee Appointed to Consider of Provision Being Made for the Better Regulation of Madhouses in England, April-June 1816, (PP1816(227)VI.249-), pp.37-8.

41. Henry Woodward, who was a patient at Ticehurst from 17 May - 7 August 1801 (Bill Book, 1792 - 1802, p.87). John Perceval (1803 - 76), who later became a patient at Ticehurst, describes how he damaged a straight waistcoat by tearing his way out of it in Dublin in 1830 ([John Perceval], Narrative of the Treatment Experienced by a Gentleman During a State of Mental Derangement. Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity, (London: Effingham Wilson, 1838), p.56). Bryan Procter (1787-1874), one of the Commissioners in Lunacy, implies in his memoir of Charles Lamb that Charles and Mary owned a straight waistcoat for her use:
 Whenever the approach of one of [Mary's] fits of insanity was announced by some irritability or change of manner, [Charles] would take her under his arm to Hoxton asylum... They used to carry a strait waistcoat with them.
 (Quoted by Augustine Birrell in his introduction to Charles Lamb's The Essays of Elia, (London: Everyman, 1901), p.xx).

42. See, for example, Bill Books, 1792-1802, pp.19, 32, 49, 63, 65, 76 & 82; 1802-11, pp. 4, 16, 35, 44, 49 & 62; 1811-19, pp. 17, 21, 52, 62 & 72. Elizabeth Latter was charged for both broken windows and broken chamber-pots in July 1795 (ibid., 1792-1802, p.35).

43. Entries which do not specify what the basic charge included, but where separate payments were made for washing and/or medicines can be found, for example, in ibid., pp.18, 22, 28, 35, 36 & 40. Entries where the basic charge specifically includes wine and washing can be found on pp.66 & 67; entries where it specifically excludes the same can be found on pp.72, 74 & 78.

44. For example in ibid. pp. 5, 22, 23 & 35. Only two entries specify the medicine given: Mr Acton was given 'A Draught', 'Mixture' and 'Drops'; and Mr Holmwood was also given 'Drops' (ibid. pp. 37 & 43).

Samuel Tuke recommends the use of alcohol in diets for melancholia (Description of the Retreat. An Institution near York for Insane Persons of the Society of Friends. Containing an Account of its Origins and Progress, the Modes of Treatment, and a Statement of Cases, (York: W.Alexander, 1813), p.128).

45. See note 33. Charles White, A Treatise on the Management of Pregnant and Lying-In Women. Together with Some New Directions Concerning the Delivery of the Child and Placenta, (London: for E.& C.Dilly, 1773), p.67 recommends only minimal bleeding during pregnancy for physical disorders; Thomas Denman, An Introduction to the Practice of Midwifery, (London: J.Johnson, 1801), advises against the use of 'powerful medicines, and very severe treatment' in cases of puerperal mania (see Richard Hunter and Ida Macalpine, op.cit. note 5, p.797).
46. Advertisement for Ticehurst, 26 January 1793, loc.cit. note 13; Roy Porter, op.cit. note 36, p.18.
47. Purchases included: bonnets, coats, cotton caps, flannel, hair-ribbon, handkerchiefs, hose, irish cloth, linen, shawls, shirts, shoelaces, stockings, suits, waistcoats, a new wig, and worsted. Payments were made to the barber, glover, hairdresser, mantua-maker, shoemaker and tailor. (Bill Book, 1792-1802, pp.1, 4, 24, 26, 49, 55, 63, 67, 68, 73, 78 & 86).
48. See, for example, ibid., pp.11, 17, 29, 40, 45, 74 & 88; 1802-11, pp.34 & 40; 1811-19, pp.7 & 68. Thomas Fallows (fl.1705) and David Irish (fl.1700) were two early eighteenth-century madhouse-keepers who recommended generous diet for their patients. The Leicester madhouse-keeper Thomas Arnold (1742-1816) also stressed the importance of 'good nourishment' for lunatics in his Observations on the Management of the Insane; and Particularly on the Agency and Importance of Humane and Kind Treatment in Effecting Their Cure, (London: 1809). (All cited in Richard Hunter and Ida Macalpine, op.cit. note 5, pp.279-80, 293 and 468).
49. Bill Book 1792-1802, pp.29 & 34.
50. Samuel Tuke, op.cit. note 44, pp.130 & 154-5. Benjamin Faulkner (d.1799), the owner of a private madhouse at Little Chelsea in London, recommended exercise as part of treatment in his Observations on the General and Improper Treatment of Insanity: with a Plan for the more Speedy and Effectual Recovery of

- Insane Persons, (London: H.Reynell for the author, 1789), p.23; and William Pargeter (1760-1810) included recommendations regarding exercise in his Observations on Maniacal Disorders in 1792 (Richard Hunter and Ida Macalpine, op.cit. note 5, p.540).
51. Richard Hunter and Ida Macalpine, op.cit. note 1, pp.282-4.
 52. Quoted in William Ll. Parry-Jones, op.cit. note 1, pp.183-4.
 53. See, for example, Bill Books 1792-1802, pp.10, 22, 32, 38, 42, 67 & 82; 1802-11, pp.2, 10, 41, 46, 57, 65, 83 & 93; 1811-19, pp.22, 64, 72, 81 & 131 for payments for shoe making/mending. Fishing tackle was paid for in ibid., 1792-1802, pp.19, 31, 34 & 47. Only Daniel Lintall paid for 'horse-keep' (see note 49); other patients paid for 'horse-hire' in ibid., 1802-11, p.40; 1811-19, pp.33, 45, 48 & 54.
 54. See note 49. Laurence Sterne, The Beauties of Sterne, (London: 1783), which had run through ten editions by 1787; William Endfield, The Speaker; or, Miscellaneous Pieces, Selected from the Best English Writers, (London: 1774), which went through many editions up to 1858. Both of these books were popular collections of quotations, which would require only a limited span of concentration at one reading: they would therefore be particularly appropriate reading for a patient with limited voluntary control of attention.
 55. Richard Hunter and Ida Macalpine, op.cit. note 1, pp.66 & 71. Benjamin Faulkner, loc.cit. note 50, also recommended 'presenting objects of amusement, directing the attention, and humouring the imagination in those little sallies which sometimes indicate a desire of mental exertion.'
 56. See Bill Books, 1802-11, p.35; and 1811-19, pp.25, 45, 61 & 99.
 57. ibid., 1802-11, p.99 and 1811-19, p.45.
 58. ibid., p.45..
 59. Mr Green came with his mother in July 1802 (ibid. 1802-11, p.22). Mrs Hayes and Mrs Chatfield came with servants in February 1799 and April 1803 respectively (ibid., 1792-1802, p.61 and 1802-11, p.13).
 60. See, for example, ibid., 1792-1802, pp.10, 28, 31,

56, 72, & 85; 1802-11 pp.28, 45, 57, 78, 92, & 99; 1811-19 pp.45, 66, & 120.

61. Roy Porter, op.cit. note 36, p.20.
62. William F. Bynum, op.cit. note 35, p.319. As Roy Porter argues: 'No eighteenth-century psychiatric writer dismissed the use of constraint entirely, but many argued that it was at best a necessary evil.' (op.cit. note 36, p.19). Even Thomas Arnold, a keen proponent of non-restraint, suggested mechanical restraint was a necessary practical measure in dealing with poorer patients: 'Chains should never be used but in the case of poor patients, whose pecuniary circumstances will not admit of such attendance as is necessary to procure safety without them.' (Quoted in Richard Hunter and Ida Macalpine, op.cit. note 5, p.469). Similar distinctions cannot explain the instances of restraint at Ticehurst: at one guinea a week, Samuel Sands' fees were average; Henry Woodward paid extremely high fees, of over five guineas a week (see notes 30 & 39).

William F. Bynum emphasises the distinction between fear and kindness in the kind of psychological appeal being made to patients' minds through moral treatment (loc.cit. in this note). Francis Willis had argued that: 'The emotion of fear is the first and often the only one by which (the insane) can be governed' (Richard Hunter and Ida Macalpine, op.cit. note 1, p.275). In contrast, William Pargeter claimed to alternate 'mildness or menaces as circumstances direct'; John Ferriar (1761-1815), physician at Manchester Lunatic Hospital, argued against 'exciting pain and terror'; and Joseph Mason Cox (1763-1818), proprietor of Fishponds private asylum near Bristol, favoured 'Gentleness of behaviour' (quoted in Richard Hunter and Ida Macalpine, op.cit. note 5, pp. 539 & 545; and in Roy Porter, loc.cit. in this note).

63. William Pargeter also claimed to be able to control patients with an authoritative look (see Richard Hunter and Ida Macalpine, op.cit. note 5, pp. 538-9). Nancy Tomes includes a valuable historical discussion of the feelings of mental patients families and friends surrounding committal in the American context during the mid-nineteenth century in A Generous Confidence. Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883, (Cambridge & New York: Cambridge University Press, 1984), pp.ix, 13-14 and 90-128.
64. [John Perceval], op.cit. note 41, pp.142, 147-8 &

- 149.
65. ibid., p.137.
 66. Account of Patients Admitted, 1828.
 67. Bill Book, 1792-1802, p.72.
 68. ibid., 1802-11, index.
 69. Revd Chambers paid three guineas per week; Revd Loftly and Mr Darnay paid 2 guineas per week each (ibid., 1792-1802, pp. 49 & 72; 1802-11, p.68).
 70. ibid., 1792-1802, pp. 26, 31, 46, 49, 61, 72 & 86; 1802-11, pp. 5, 27 & 87; 1811-19, pp. 61, 90, 110 & 111. Account of Patients Admitted, 1828; Medical Register (1783), p.112.
 71. Bill Books 1792-1802, pp. 10, 26, 31, 46, 49, 61, 72, & 87; 1802-11, pp. 5, 27 & 87; 1811-19, pp. 41, 61, 64, 78, 90, 103, 110 & 111. William Ll. Parry-Jones describes the clientele the Willises attracted as 'fashionable and noble' (op.cit. note 1, p.76).
 72. A Return of the Number of Houses in Each County or Division of the County Licensed for the Reception of Lunatics, PP1819 (271.) xvii.131., pp.2 & 4.
 73. The population of Hastings rose from 3,848 in 1811 to 6,085 in 1821 - an increase of almost 60%. During the same period, the population of Sussex as a whole increased by only 20% - from 189,245 to 233,019. The population of Rye rose by just over 30% - from 2,681 to 3,599; and that of Lewes by only just over 10% - from 6,221 to 7,083 (Abstracts of Population Returns for 1811 (PP1812(316.)(317.)XI.1-), pp.336-8 & 341; and Population: viz Enumeration and Parish Registers of Great Britain; According to the Census of 1821 (1822(502.)XV.1-), pp.336-7 & 341.
 74. 'Yalding' is sometimes written as 'Yalden' in both the account books, and the Country Register. In 1811 there were 312 families in Yalding in a population of 2,059. By contrast, there were 287 families in Burwash in a population of 1,603, and 415 families in Mayfield in a population of 2,079. (Abstracts of Population Returns for 1811 (PP1812(316.)(317.)XI.1-), pp.141, 336 & 339.
 75. MH51/735 79595, pp.62-4 & 121.

76. Only non-pauper admissions were required to be reported. The number of admissions to Ticehurst from 6 April 1802 - 23 December 1812 recorded in the bill books (excluding paupers) was 254, compared with 97 admissions listed in the Country Register. As further evidence of the incompleteness of the Country Register, William Ll. Parry-Jones cites the case of Droitwich Lunatic Asylum, where 619 cases were reported to have been admitted between 1792 and 1816, only two of which appear in the Country Register (op.cit. note 1, p.46).
77. Account of Patients Admitted, 1828.
78. See note 17; Bill Book 1811-19, p.22.
79. Copy of an early certificate:
 To Mr Newington, Surgeon Ticehurst.
 By the direction of Mr Johnson, of
 Tenterden, I advise you to receive
 into your house Mr S. Johnson, jun.,
 his son, who from epileptic fits is
 rendered incapable of conducting
 himself in society.
 Dated 5 April 1803 and cited in H.F.H.Newington &
 A.S.L.Newington, 'Some Incidents in the History
 and Practice of Ticehurst Asylum', Journal of
 Mental Science, 47 (1901), p.64.
80. Admission of Patients, 1843-5.
81. For a description of the restricted role women played in legal transactions in the eighteenth century see Roy Porter, English Society in the Eighteenth Century (London: Penguin Books, 1982), p.38.
82. Account of Patients Admitted, 1828; and Register of Admissions, 1845-81.
83. 32 male and 31 female patients were eventually readmitted. Of these, four had a total length of stay of more than five years: Musgrave Thomas Gray, admitted 28 November 1812 - 25 April 1815 and 13 July 1815 - 2 July 1821; Lawrence Rogers, admitted 3 March 1814 - June 1815 and October 1815 - 22 June 1863; Catherine Cobb, admitted 29 April 1815 - 29 October 1815 and 31 October 1818 - 13 March 1867; and a Miss Hawkins, admitted 15 September 1815 - 5 June 1816 and 19 September 1816 - 10 January 1823. (Bill Books 1811-19 and 1819-26; Register of Discharges and Deaths, 1845-90).
84. 7 men and 3 women were transferred to St Luke's; 2

men were transferred to Bedlam; 1 man was transferred to Fisher House, and 1 woman to Holly House in Hoxton (Bill Books 1795-1802 pp. 17, 19, 21, 25, 37 & 44; 1802-11 pp. 9, 26, 32, 54 & 55; 1811-19 pp. 62, 95 & 104).

85. ibid., 1792-1802, p. 18.
86. William Courthope. Son of George Courthope of Whiligh Manor. BA (Cantab) 1791. Rector of Plumpton, Sussex 1796. Rector of Westmeston with Chillington Chapel 1821-47. (Alumni Cantab.).
87. For the effect of the Napoleonic wars on the British economy see G.D.H.Cole and Raymond Postgate, The Common People, 1746-1946 (London: Methuen & Co., 1971 edition), p.191.
88. Epitaph in Ticehurst parish church, which reads:
 Reader! May the Father of all Mercies
 grant that at His awful Tribunal thou
 may'st appear with the same Joy and
 Confidence which shall be felt by this
 amiable and excellent man.
89. Bill Book 1811-19, pp.3, 22, 42, 110 and 112.
John Mayo, a prominent fellow of the Royal College of Physicians. BA(Oxon) 1782; MD 1788. Censor of the Royal College of Physicians 1790, 1795, 1797, 1804 & 1808, and Harveian orator 1797. Physician to the London Foundling Hospital 1787-1809, and Middlesex Hospital 1788-1803. Physician in Ordinary to the Princess of Wales. Lived in Tunbridge Wells during the summer months, where he '...took the undisputed lead in the medical business and emoluments of that town and neighbourhood' (Munk's Roll II, p.396). Settled there in 1817. (Dictionary of National Biography).
90. M.A.Lower, op.cit. note 19, p.254.
91. H.F.H. & A.S.L.Newington, op.cit. note 79, p.63.
92. See Plate 5.
93. Bill Book, 1811-19, pp. 69 & 98.
94. William Ll. Parry-Jones discusses how far private madhouse-keepers' motives were primarily mercenary (op.cit. note 1, p.84-8).
95. Of those patients admitted before 31 July 1817 who eventually stayed more than 20 years, six paid the same on 31 July 1817 as they had paid on admission

(meaning a decrease in real terms), and six had increased their fees. Despite post-war deflation, nine eventually paid more than they had on admission, two paid the same, and one decreased his fees (Bill Books 1792-1802, 1802-11, 1811-19, 1819-26, 1826-32, 1832-9, 1840-6, 1846-54, 1854-61).

96. Mrs Owen, who came at £250 per annum (ibid., 1811-19, p.95).

CHAPTER 2: PHYSICIAN, SURGEON AND PATIENTS - THOMAS
MAYO, CHARLES NEWINGTON AND JOHN PERCEVAL

At the Sussex midsummer quarter sessions in 1817, John Mayo was appointed visiting physician to Ticehurst Asylum, on a retainer of eight guineas a year.¹ In the same year, his son Thomas (1790-1871) published Remarks on Insanity, Founded on the Practice of John Mayo, M.D.. Following his father's death in 1818, Thomas Mayo took over the practice in Tunbridge Wells, including the appointment as visiting physician.² Since, in addition to the routine inspection this appointment required him to carry out, Thomas Mayo acted as a consulting physician to patients in the asylum, it is possible to delineate a fuller picture of the kind of treatment which may have been offered to patients in Ticehurst in the 1820s and 1830s than when the asylum first opened.³

Thomas Mayo was educated with private tutors and at Oriel College, Oxford, where he took a first class degree in Literae Humaniores in 1811. His tutor, Dr Copleston (1776-1849), claimed Mayo's final classical examination was the best he had ever heard. In 1813 Mayo was elected a fellow of Oriel College, and went on to take a B.M.(1815) and D.M.(1818). Amongst those to whom he could have talked over dinner and in the common room, were two men who were to help shape the religious and

educational character of Victorian England, John Keble (1792-1866) and Thomas Arnold (1795-1842); as well as the future Archbishop of Dublin, Richard Whately (1787-1863), through whom Mayo met the future Professor of Political Economy at Oxford, Nassau Senior (1790-1864), who was then a student and fellow at Magdalen College. These Oxford connections remained strong enough for Mayo to be invited in 1828 to contribute to a new all-party quarterly, the London Review, which Whately and Senior were founding.⁴

In Remarks on Insanity, Mayo occupied the position identified by William Bynum as the majority one amongst medical men concerned with the treatment of insanity in early nineteenth-century Britain. That is, that insanity was ultimately a physical disease.⁵ Although Mayo argued that mental disease could have mental causes, it was implicit from the rest of his argument that these could never be sufficient. Insanity was always accompanied by physical changes requiring physical treatment, and although courteous attention should be paid to patients' feelings, Mayo assessed the relative value of medical and moral therapies in this way:⁶

We will suppose a patient left negatively, if we may use the expression, in respect of moral regimen. He is continued in the same comfortable state which he was in before he became insane; - he is treated, when violent, with humanity, but he is repressed by the strait waistcoat. No

precaution is taken to break morbid associations - no care to furnish him with others that are agreeable - no attempt to make an impression by well-chosen appeals upon his wavering intellect... Allow us the medical regimen which we have sketched, and we shall indulge fair hopes of curing the patient. But, reverse the means of cure; let the degree of medical regimen be no more than analogous to the moral in the first case which we have supposed, - we shall no longer answer for the event: though we are very far from denying, that even here nature may cure the patient in spite of the physician.

From this perspective, the extensive new 'pleasure grounds' at Ticehurst, and attempts to rouse patients' interest in rational recreations would be seen as having negligible therapeutic value.

As Bynum has argued, Mayo's repudiation of moral therapy was partly inspired by the threat which lay therapists might pose to the medical profession if insanity were seen as a psychological rather than a physical disorder - he wrote 'To vindicate the rights of [his] profession over Insanity, and to elucidate its medical treatment.'⁷ Yet a deeper fear which was implicit in his attacks on 'metaphysical views of insanity' was the challenge which psychogenetic theories of mental disorder posed to the Christian theological doctrine of free will.⁸ For the same reason he attacked the vitalism of Cullen and other 'solidists', whom he perceived as seductively and almost imperceptibly opening the door to a materialist philosophy of mind:⁹

The doctrines of the solidists, as applied to the subject of insanity, were likely to tempt research into a metaphysical channel... In passing from the history given by Dr Lorry of the physical principles on which past impressions are renewed, even when the cause, which originally excited them is no longer present, to the partial excitement and collapse of faculties by which Cullen accounts for the phenomena of delirium, we scarcely perceive that we are making a transit from the physical to the moral world. The doctrines of spasm have nearly as little reference to physical facts as if they appealed for their evidence to consciousness.

Mayo's Christian rectitude in refusing to countenance any speculative theory which twilighted the necessary division between moral and physical phenomena was underpinned by an appeal to the authority of the ancients, and classical humoralism, with its physicalist theory of insanity.¹⁰

However, Mayo's confidence in the radical nature of psycho-physical dualism was sufficiently robust for him to welcome scientific investigation into the physical pathology of insanity. His criticism of the Leicester physician Thomas Arnold, and Bedlam apothecary John Haslam, was indeed that they did not pursue the correlation between their findings in post-mortem dissections and the mental and physical symptomatology of insanity - but particularly its physical symptoms - hard enough.¹¹ He believed Haslam's dissections provided confirmatory evidence that insanity was due to a

plethoric congestion and inflammation of the brain.¹² Although Mayo never attempted to substantiate this physical pathology through dissections of his own, the assertion of an equally strong dualism in his surgeon brother Herbert's Anatomical and Physiological Commentaries (1822) on the nervous system, suggest that this need not have been because Thomas Mayo feared that a fuller articulation of the physiological processes which accompanied mental activity might undermine revealed religion; indeed, to Herbert Mayo it was logically inconceivable that it could.¹³

In his reasons for criticising the Scottish schools of Cullen and Brown, and confidence that genuine scientific advance could do nothing to fracture the central tenets of Anglican theology, Mayo's position was close to that of the Bristol ethnologist and physician of insanity, James Cowles Prichard (1786-1848).¹⁴ However, Mayo was more cautious than Prichard in welcoming the work of the revolutionary French alienists Pinel and Esquirol: although he praised the 'utmost exactness' of their case histories, he felt that even their new and more condensed nosologies were over-precise, and forcibly disrupted the natural continuities between disorders, as well as over-emphasising a mental rather than a physical pathology of insanity.¹⁵ His reservations were thus much broader than Prichard's initial rejection of Pinel's

concept of 'manie sans delire'.¹⁶ Indeed, writing only two years after the battle of Waterloo, Mayo felt it was advisable to apologize for:¹⁷

...resorting to France for a history of insanity... Let it be remembered, that the French revolution has given the physicians of that country an advantage, to which we have nothing analogous, in supplying an immense mass of simultaneous cases.

But like Prichard, Mayo advocated an active, interventionist medicine, whilst keeping a watchful eye on its implications for the Christian faith.¹⁸

Prichard also subscribed to the view that disease was generally the result of local plethoric inflammation; and the medical treatment which Mayo recommended in cases of insanity was, like Prichard's practise at St Peter's Hospital in Bristol, heroic in character.¹⁹ Since insanity was seen as being due to vascular congestion of the brain, the therapy Mayo advised was primarily depletive: bleeding and cupping; the almost daily use of purges and nauseants; and the application of caustic issues and setons as counter-irritants. Sweat-promoting and cooling agents were also, although less strongly recommended.²⁰ Mayo criticised the Chester surgeon George Nesse Hill (1766-1831) for attempting to introduce a distinction between sthenic and asthenic cases, and prescribing tonic medicines for asthenic patients. He reiterated that all cases of insanity were plethoric; and

argued that even in cases of extreme physical weakness, tonic medicines were inadvisable, although a tonic regimen was recommended.²¹ He advised against the use of sedative drugs, rather than depletion, to quell excitement.²²

What little evidence there is in the accounts reflecting treatment at Ticehurst during these years does not contradict this profile, although it is impossible to estimate whether depletive therapies were as prominent as Mayo advised. In July 1818, a patient called John Chatfield 'began with three glasses of port per day', presumably as part of a tonic diet.²³ Other patients also made routine payments for port and other wines.²⁴ However, payments made to Dr Mayo do not specify what treatment was given, nor whether medicines were prescribed.²⁵ Only one patient was listed as being charged for 'medicines', and her bill does not specify what these were.²⁶

As visiting physician, Mayo was relatively unconcerned with the day-to-day practical problems of managing the insane. It is with one of these that Charles Newington's only published article is concerned. 'An Instrument invented for administering Food and Medicine to Maniacs by the Mouth, during a closed state of the Teeth' (1826) vividly conveys the face-to-face confrontation between

patient and doctor that force-feeding involved. 'I can truly aver', wrote Charles Newington:²⁷

...that no part of actual and personal superintendence can be more disagreeable or revolting than the task of forcing food upon a contumacious patient by the methods usually pursued.

He claimed that his own method - of passing a piece of curved metal piping through the gap behind the patient's molar teeth, into which food could be injected from a syringe - resulted in fewer cut lips and broken teeth than feeding with a feeding-cup or 'boat'.²⁸ This apparatus was in fact a modification of the stomach-pump which had been invented by a local manufacturer of hydraulic syringes, John Read (1760-1847).²⁹

Charges made to two patients in 1827 and 1828 for 'Waistcoats (strait)' suggest that mechanical restraint continued to be used at Ticehurst.³⁰ This impression is confirmed by John Perceval's account of his confinement at Ticehurst in 1832. Following an escape attempt in April, Perceval had his hands confined at night because the attendant was scared to be alone with him:³¹

After having tried about six or seven bolts, one was deemed sufficiently tight to ensure my safety, and I was left... Mr Newington told me that many patients requested to have the manacles put on. I answered "I hope they like it," and thought such people are surely made for these houses.

However, as for the earlier period, it is difficult to

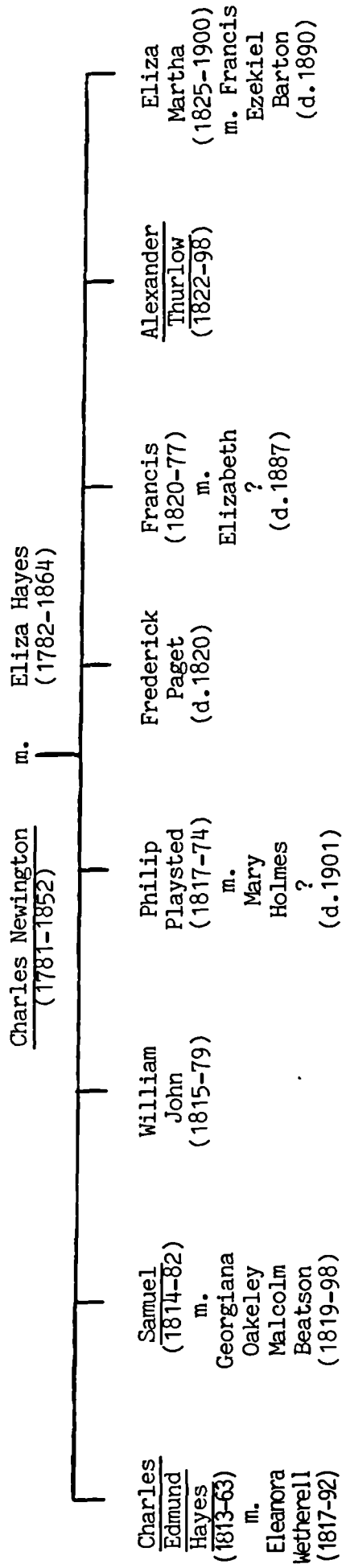
assess how routinely mechanical restraint was used.

Although after Charles Newington's death in 1852 the Commissioners in Lunacy claimed that he had:³²

...gradually but steadily discard[ed] the use of instrumental restraint to an extent which of late almost amounted to its abolition.

it seems likely that, if this was more than a rhetorical tribute to a mid-nineteenth century psychiatrist, it was a policy which Charles Newington pursued most vigorously after the non-restraint movement gained popularity in the late 1830s and early 1840s.³³ Commissioners' reports in the early 1840s commented regularly on how few patients were restrained; and on 15 June 1844 were able to report that no patients were subject to mechanical restraint.³⁴ It is however clear that by the early 1830s, seclusion was used as well as restraint. Thus one of John Perceval's fellow-patients, John Allsopp, showed Perceval a room 'in which he was confined when violent', although Perceval does not make it clear whether or not this room contained instruments of restraint.³⁵ In 1838, Mayo wrote of the value of 'coercion gently applied' in protecting patients against themselves, as well as the importance of 'Perfect quiet and a darkened room'.³⁶

The death of Jesse Newington in 1819 seems to have made little difference to the running of the asylum. In May



NEWINGTON FAMILY TREE: III

1819, the first recorded admission was made to Charles Newington's own home, the Highlands, certified by Thomas Mayo and Samuel Playsted Newington; but the house was not licensed to take more than one patient until 1830.³⁷

These were prosperous years for the Newington family - although admissions began to decline, by 31 July 1820 the number of patients resident in the asylum had risen to fifty (see Tables 12 and 13). Despite post-war deflation which returned most prices to pre-war levels, the median charge for first admissions remained one guinea per week until the late 1820s, and that for patients resident in the asylum dropped by only one quarter, to one and a half guineas per week (see Tables 14 and 15).

A uniquely surviving letter, from George Newington to his daughter Fanny, describes how the Newington family celebrated Martha Newington's eighty-second birthday in July 1822:³⁸

...it far surpassed anything I have seen for many years. We pitched your Uncle Charles' marquee, which is a very large one, and a large booth a little above the stable, with six willows very handsomely decorated with all sorts of fine flowers, likewise eight willows on the side of the booth. I assure you they were very elegant, the bottom of the booth lined with hop-bagging, and every part so well secured that no-one could catch cold. The tables all mahogany sixty-five feet long, seventy-six dishes with roast-beef, lamb, chickens, ducks, hams etc., likewise nine tippy cakes and a profusion of pastry, raspberry creams etc. etc.. Music and cricket in the afternoon. All the boys

dressed in white trousers and jackets. Tea in the marquee in the evening, after which we had a most excellent dance, first in the booth and then adjourned to the front of the Vineyard where we kept it up till a late hour. Your grandmother sat at the head of the table under a canopy of large sunflowers. She never looked better and I assure you she was very highly gratified and delighted. We drank her health with three times three. The tables were fixed rather upon a descent, therefore she had a most pleasing view of all her own children (except one) and grandchildren to the number of sixty-four. Altogether it had a most lively and impressive effect. We had ten servants to wait on us. It was conducted altogether in the most orderly and quiet way imaginable.

The next day we dined forty-five off two very fine salmon etc., and on Friday we had a very large turbot and soles. The boys and girls kept it up till Saturday when your aunts etc. finished the day with a lively game of Trap-Ball. All cleared off without one cross look or contradiction - very fine weather, children all healthy and well-looking. I forgot to say, your Aunt Charles was put to bed on Wednesday, very sly, as we were dancing, of a seventh son of the seventh son, his name is to be Alexander.

The full measure of this prosperity needs to be seen against the surrounding economic depression in the predominantly agricultural counties of Sussex and Kent.

Demobilization after the Napoleonic Wars had led to an influx of ex-soldiers and sailors - about one sixth of the adult male population in England as a whole - seeking alternative employment. Together with the 'Speenhamland' system, which made parishes liable to bring very low

wages up to the minimum bread-line, this increased demand for employment tended to push wages down. In addition, the late-eighteenth and early-nineteenth century enclosure of common land meant poorly-paid labourers were unable to subsidize their standard of living through growing crops of their own. Although real poverty hit hardest at agricultural wage-earners, the resumption of foreign imports meant that prices fell, so that farmers and tradespeople also suffered a decline in income. Tenant farmers in particular, whose rents stayed high despite deflation, were increasingly financially stretched. Land-owners faced rate increases to cover the cost of rising pauperism.³⁹

In August 1823, William Cobbett rode within five miles of Ticehurst, fulminating against the great wealth of two of Sussex and Kent's richest land-owners, Marquis Camden and the Earl of Abergavenny. Leaving Tunbridge Wells he reflected:⁴⁰

This little toad-stool is a thing created entirely by the gamble; and the means have hitherto, come out of the wages of labour. These means are now coming out of the farmer's capital and out of the landlord's estate; the labourers are stripped; they can give no more: the saddle is now fixing itself upon the right back.

Yet, if Decimus Burton's elegant new buildings on Claverley Crescent and Monson Colonnade failed to re-establish Tunbridge Wells as a spa-town comparable to

Brighton or Cheltenham, the speculators who employed him were shrewd in estimating the leisure and service industries - of which Ticehurst may be seen as part - as one of the few growth areas in an impoverished rural economy.

Low prices and depressed wages were to Charles Newington's advantage in running an institution. Although no record survives of wages paid at Ticehurst House or Asylum during this period, the census of 1841 shows that most of the attendants and domestic servants who worked there originated from neighbouring villages in Sussex and Kent, and it seems likely that this would also have been the case in the 1820s and 1830s.⁴¹ As an employer, Charles Newington was able to adopt strict attitudes towards his employees. A Visitors' report in November 1827 commented that:⁴²

With regard to the Attendants, we consider it an advantageous point in the arrangement of this House, that they are not allowed to leave the Establishment as keepers, or allowed to deviate into habits of irregularity and disorder by being removed from the eye of their Master.

Unfortunately, details of the hours worked by attendants, which would make it possible to assess what this meant in practice, are unavailable. It is however clear from the 1841 census that many of the attendants and domestic staff lived in the asylum. One of Charles Newington's later inventions was a 'tell-tale' clock, which recorded

the movements of night attendants, for which he was granted a patent by Queen Victoria in 1846.⁴³

The increase of pauperism in Sussex and Kent did not lead to more pauper admissions to Ticehurst. On the contrary, the proportion of patients admitted who were paupers declined, and the last pauper admission to be shown in the accounts was made in 1825 (see Table 12.1). Official statistics suggest the number of pauper admissions may have been higher than the number of patients who were listed as paupers in the accounts. Thus in 1844, Charles Newington told the Commissioners in Lunacy seventy paupers had been admitted between the date of opening and 31 December 1838. This is compared with a total of fifty-six first admissions who are listed as paupers in the accounts. The real incidence of pauper admissions was therefore probably slightly higher than is clear from the accounts, although it is also worth observing that the official statistics do not cross-tabulate. Certainly no pauper patients were admitted after 31 December 1838.⁴⁴

Rather than this being a policy decision by Charles Newington not to accept pauper patients, it seems probable that, burdened by increasing numbers of dependants, parish overseers were unwilling to pay fees as high as one guinea a week. In 1825, a second private

asylum had been opened in Sussex at Balsdean in Rottingdean. This asylum which took mainly pauper patients, transferred to a former army barracks at Ringmer near Lewes in 1829. Up to twenty pauper patients were maintained there, at a cost of 15s. per week each. Nevertheless, magistrates who visited the asylum in 1830 complained that even this charge was too high.⁴⁵

Although a return for 1830 lists more pauper lunatics than were maintained at Ringmer as being cared for in private madhouses, it is also known that some pauper lunatics from Sussex were sent to metropolitan asylums.⁴⁶ In 1833, Kent became one of the minority of counties in England which built a county asylum for pauper lunatics under permissive legislation of 1808.⁴⁷ The rise in fees at Ticehurst in the late 1820s and early 1830s makes the maintenance of pauper lunatics there seem increasingly unlikely (see Tables 14 and 15).

However, the economic depression of these years is reflected in the continuing occasional instances of patients who were unable to settle their bills. Thus in May 1819, a Mr Robinson paid only ten pounds of a twenty-one pound bill because 'he could not pay any more' (sic); in 1822, a Mr Ranger was given one and a half guineas of an £8.12s.6d. bill; in 1823, a Miss Bertrand was given four weeks treatment free of charge; in 1825, George Pryer was given £1.4s.6d. of a £7.10s.6d. bill; in

1827, a Mrs Cosham from Laughton and a Mr Boorman from Cranbrook were given £5.13s.0d. and £3.19s.8d. respectively; and in February 1829, Harriet Cruttenden was given eight weeks treatment free of charge.⁴⁸ Other patients were permitted to settle their bills in kind: by flour, by timber, by faggots and by groceries.⁴⁹

One of Charles Newington's obituarists recalled his generosity towards patients:⁵⁰

...there were at the Asylum, for years, many inmates who had seen better days, who had been admitted upon a nominal payment, and who in the course of time had become almost friendless: these, however, were fed, clothed, and cared for, on a pittance which scarcely remunerated him for their daily bread.

However, at least until 31 July 1830, most patients who would eventually stay more than twenty years in the asylum paid either the same fees or more than when they were admitted. Only five patients had reduced their fees, by a total of £165 a year, whilst the increase of 6 guineas a week paid by one patient alone from December 1827 onwards amounted to over £300 a year.⁵¹ The only patient who actually became bankrupt was removed from the asylum.⁵² The waiving of fees in the cases illustrated above enhanced Charles Newington's reputation for kindness and generosity, without in any way damaging the increasing profitability of Ticehurst.

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A South-East View of the Asylum at Ticehurst, Sussex.

Plate 1

88

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A View of the Pleasure Grounds and Aviary.

These profits were ploughed back to improve the attributes of the asylum. As the obituarist above rather laconically expressed it:⁵³

There was always some new conservatory or aviary, some pagoda or flower garden, some evergreen alley or artificial fountain, to construct, in order to make the place more attractive and comfortable.

In 1826, a special gallery for patients was built in Ticehurst parish church; and in the early 1830s work was begun on a chapel in the asylum.⁵⁴ Following his mother's death in 1831, Charles Newington was able to buy his brothers' and sisters' shares in the property at Ticehurst.⁵⁵

The prospectus drawn up in 1827-8 reflected the lavish scale of Ticehurst (see Plates 1 and 2). Strikingly, all the engravings are of the asylum's exterior and grounds rather than the interior. The presence of children - perhaps intended to represent Charles and Eliza Newington's youngest son and daughter, Alexander and Eliza - and of men riding out on horseback and in a gig suggest the desired impression was of an ordinary, if substantial, country house. It is not clear, for example, that windows to the patients' bed and sitting rooms were barred.⁵⁶ The grounds' total appearance, with sheep and cattle grazing, and gardeners at work, suggest an ordered and well-tended estate. It is difficult to imagine struggles to force-feed patients, or get them

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The Moys-house and part of the Pleasure Grounds.

into strait waistcoats going on inside here. Only the presence of attendants walking several paces behind their charges in some of the smaller illustrations reflected the supervisory role of the asylum (see Plate 3).

From the ground-plans of the asylum, it is possible to estimate what proportion of patients had single bed and sitting rooms, assuming that all rooms were occupied. Taking the number of patients resident on 31 January 1828 (31 male and 19 female patients) the breakdown would be as follows, if no more than two patients shared any one bedroom: 11 men and 9 women who had private bed and sitting rooms; 4 women who had private bedrooms but shared the public sitting rooms; 2 men who had private sitting rooms but shared a bedroom; and 18 men and 6 women who shared both bed and sitting rooms. There were four public sitting rooms for men, and only two for women, suggesting about four or five patients used each one. This profile bears no simple correlation to the distribution of fees paid, which would imply that other factors (such as attendance and diet) also influenced fees.⁵⁷

In October 1830 the economic distress of the agricultural labourers in Sussex and Kent erupted in a series of riots, rick-burning and machine-breaking, which swept across both counties. Ticehurst, as well as nearby

Burwash and Mayfield, were amongst the parishes where the overseers to the poor were carried out of the parish in the carts to which labourers seeking poor-relief were sometimes harnessed. There were disturbances at Frant and Northiam; and in Cranbrook, Tonbridge and Tunbridge Wells farmers and tradesmen refused to act as special constables to quell the disturbances unless rents and tithes were reduced. At Goudhurst, rioters smashed threshing machines, and twenty-five dragoons were brought in to disperse the crowd.⁵⁸

Although no description survives of how patients at Ticehurst responded to these disturbances, John Perceval has left a vivid description of his feelings during the Bristol riots in the following October, when he was a patient at Brislington House:⁵⁹

The seditious conversation and tone of the servants, and their accounts of the state of mind of the peasantry, gave me great anxiety. The heavy dragoons were quartered in the neighbourhood, and one day I saw a troop of them exercising their horses down the road. I augured ill of their trustworthiness and discipline from their conduct... At that time, I longed to see a train of artillery coming down the road, and looked for it daily; for I knew that they would keep order, but the government acted the part of madmen... The night the city was on fire, Hobbs and Poole [his attendants] came into my bedroom to see the flames; I was tied in bed. Poole proposed to untie me, that I might see it; but Hobbs replied "Oh! no, no, he will only be playing his tricks."

It is easy to imagine that the riots and violence to

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property in Sussex and Kent would have been deeply disturbing to patients at Ticehurst who were already in a weakened state of mind.

John Perceval's account of his confinement at Ticehurst from February-December 1832 is a unique source for details of what the interior of the asylum was like.⁶⁰ His descriptions are so precise that it is possible to locate the corridors (although not the individual rooms) on the West Front in which he was confined on ground-plans of the asylum (see Plate 4). It is also possible to trace the route of walks he took in the grounds on the map of the 'pleasure grounds' contained in the prospectus (see Plate 5). At £360 per annum, or six and a half guineas per week, John Perceval was one of Ticehurst's highest paying patients, and the quality of care which he received must represent the upper end of Ticehurst's range.⁶¹ However, it seems likely that the basic style of decoration and furnishings would have been the same throughout the asylum. The ethos which John Perceval described was one which approximated as closely as possible to a fairly prosperous middle-class domestic environment.

As a high fee paying patient, John Perceval had both a single bedroom and a single sitting room. This is how he described his sitting room:⁶²

[It] had the walls papered, the floor carpeted, a sofa in it, a small book-case, mahogany table and chairs, a marble chimney-piece, a large sash-window; a cheerful fire in the grate without a wire guard; and although there was an appearance of shabbiness and hardness, there was nothing unnecessarily coarse to remind me of my situation, excepting a wooden stake for stirring the fire; which, however, was meant to supply the place of the fire-irons. The absence of these, and of any lock to the door, and the heavy perpendicular iron bars at the window, alone recalled to me in my room that I was a prisoner.

Wooden pokers were probably introduced at Ticehurst after an incident in which Charles Newington was hit over the head with an iron poker by a patient.⁶³ In addition to the items described above, Perceval was given a writing-desk and a piano.⁶⁴

His bedroom too was:⁶⁵

...cheerful, airy and respectable; the walls were papered...a chest of drawers stood in it, with a looking-glass, a washhand-stand and basins etc., etc., only the beds were without curtains or hangings of any description...the window, like the fellow to it in my room below stairs, had perpendicular iron bars to it.

At night, his clothes were taken from the room. An attendant slept in the room with him, but even so the door, like the door to his sitting room during the day, was bolted from outside.⁶⁶

The criticisms which John Perceval made of Ticehurst may be divided into two groups: firstly, his objections to

being closely supervised, and the object of what he experienced as individually indiscriminating, what might at a later date be called institutionalized methods of treatment; and secondly, complaints of bad management. Perceval objected to the lack of privacy caused by the nearly constant presence of attendants, and a spy-hole in the door of his sitting room through which he could be watched even when unattended; he also complained that there were no fastenings on the lavatory doors, so that other people burst in whilst he was using the toilet.⁶⁷ He resented the lack of trust with which he was treated, for example in not being allowed to travel to London to see his former physician, whom he wanted to testify to the deterioration in his health which he claimed had occurred at Brislington House.⁶⁸

More surprising than these precautions were Perceval's complaints of poor management: that the food was bad; that the asylum was cold; that pans of excrement were left to be examined in the water-closets, in poorly ventilated corridors; and that attendants and patients were frequently '...whistling, singing, fluting, fifing, fiddling, laughing, talking, running, and even occasionally dancing in the passages and wrestling.'⁶⁹ For Perceval, the tedium of 'pale and sodden' meat, 'mouldy' bread and pastry, and 'bad' beer (which was brewed on the premises) was relieved only by the

occasional glass of sherry.⁷⁰ Charles Newington denied to the Visitors that the attendants ever did anything other than 'hurry' in the corridors, but if they were indeed unable to leave the grounds of the asylum for long hours at a time, it seems likely that they would sometimes have reacted by letting off steam when no authority figures were present. Perceval made the point to the Visitors that '...the servants' office was painful and irksome, and that they needed recreation; this was combated; but Dr Mayo seemed to agree with me in part.'⁷¹ However, Perceval could also be extremely sensitive to low levels of noise: in his account of the treatment he received at Ticehurst he recalled how, when he arrived at the asylum, he could not even bear the sound of his watch ticking; and a payment in one of his bills for a new watch-glass suggests how irritable he could become.⁷²

One striking feature of the treatment Perceval received at Ticehurst was the small part played by medical therapy. Indeed he described Charles Newington as reluctant to prescribe medicines:⁷³

Mr Newington never prescribed to me any medicine whilst I was under his care. I had once or twice an attack of diarrhoea of which I complained, and then I obtained some tincture of rhubarb, and afterwards some gentian. I had a great longing for chalybeate water when I came to his establishment, but he would not allow me to have anything of the kind; he pretended it would be too strong for me. I insisted upon having some kind of tonic, and he

prescribed gentian. I suspect the neglect on his part proves his ignorance for I am confident that disorder of the imagination arises in a very great degree from a weak state of the stomach.

Yet Charles Newington's reluctance to give Perceval a tonic, even in the convalescent stage of his disorder, was of course in keeping with their proscription by Thomas Mayo, and cannot be taken as indicating an absence of medical therapy in general. It is even possible that the attacks of diarrhoea of which Perceval complained were themselves the result of the administration of purgatives.

The only other medical advice which Charles Newington gave John Perceval was when Perceval began running as well as walking during his daily exercise, and Newington warned him that running might 'overheat' his brain. This caution was clearly coloured by the recent escape attempt which Perceval had made. The centrality of at least moderate exercise to the regimen practised at Ticehurst may be inferred from the fact that the day after his escape attempt, Perceval was allowed to go out for a walk, although accompanied by two attendants rather than one.⁷⁴

How much is it possible to generalize from John Perceval's account of his experiences about treatment at Ticehurst? In the absence of further evidence, it is

impossible to say how true Perceval's complaints of bad food, inadequate heating and poor ventilation may have been. Certainly early visitors' reports were univocal in their praise for conditions at Ticehurst.⁷⁵ It is easier to substantiate the ways in which patients were encouraged to pursue rational mental activities like making music, writing and reading. There are entries in the accounts where charges were made for tuning or repairing a musical instrument, buying writing paper or books; and ground-plans of the asylum show that, in addition to public sitting rooms, there was a music room and reading room on the ground floor of the asylum.⁷⁶ The encouragement of exercise is documented by occasional entries in the accounts for horse-hire and horse-keep, as well as the walks mapped out in the 'pleasure grounds', and the presence of a bowling green in the grounds (see Plate 5).⁷⁷

Perceval was also encouraged to mix with other patients. From the accounts it is possible to identify who these patients were: Henry Charles Blincowe (who Perceval described as Mr B____, pseudonymed Blake, whose voices called him 'Harry'); Charles Nunn (Mr Nunn, since he was dead by the time of publication); Alexander Goldsmid (Mr G____th, an elderly Jewish gentleman); and John Allsopp (Mr A____p, a medical student).⁷⁸ All of these patients paid above average fees of four guineas a week or more,

suggesting that social divisions were maintained within the asylum.⁷⁹

Although Perceval described Henry Blincowe as 'imbecile', he was listed in an admissions book in 1845 as suffering from 'delusions'. Other high fee paying patients in this period with whom Perceval was not encouraged to mix - such as the the only titled patient in Ticehurst at this time, Sir William Walter Yea (1784-1862); one of Harriet Martineau's cousins, David Martineau (1798-1856), whose sister Emily was also in the asylum; and a patient called Page Keble (1779-1848) - were all described in 1842 as 'incurable', and diagnosed in 1845 as suffering from 'imbecility' or 'amentia'. Although John Allsopp was described by 1842 as 'incurable', Henry Blincowe and Alexander Goldsmid were described simply as 'not cured'.⁸⁰ This would suggest that, apart from social considerations, association with other patients who were believed to be curable was encouraged because it was thought to be morally therapeutic.

Of those with whom he was encouraged to associate, there were three patients whom Perceval described as undoubtedly insane - Allsopp, Blincowe and Nunn - all of whom eventually died in Ticehurst.⁸¹ Goldsmid is presented as possibly not mad, within the literary tradition of a seeing, philosophical fool. Not raving,

but clowning. 'I should say', wrote Perceval:⁸²

he is deceived by misapprehending a spirit of humour, and that what he urges seriously he ought to say in joke, and vice versa. He is an active, stout little man, with very white hair, a merry, good humoured, and gentlemanly countenance...he affects to be, or is, perfectly indifferent as to the recovery of his freedom, looking upon the world as so perverse and lunatic, that a wise man can have no desire to live amongst them...

Younger than Goldsmid, Perceval was less philosophical about his separation from the world. 'I might have entertained the same views,' he mused, 'if I had been confined with a female for whom I had respect and affection.'⁸³ Nevertheless, Perceval and Goldsmid struck up a friendship: walking, playing the piano and discussing religion together. Perceval pitied Goldsmid for being separated from his children, and when Goldsmid called on him one morning before breakfast, Perceval '...shut the door, and tried to make him feel himself at home'.⁸⁴

There is some historical irony here, since malpractice by the Goldsmid family in the Exchequer Bill Office had led to one of the most embarrassing fiscal crises of Spencer Perceval's government.⁸⁵ Yet like John Perceval, whose original confinement followed a period of intense evangelicalism and interest in the Row miracles, Alexander Goldsmid's mental crisis centred on religion.⁸⁶ What was at stake for Goldsmid however was not the role

of revelation in Christian doctrine, but the route which Jews should take to gain fuller social and political participation in early nineteenth-century Britain.

Whereas other Jewish-born brokers like David Ricardo had gained access to the Stock Exchange - where, until 1828, a court of aldermen's regulation limited Jewish membership to twelve - because they were Christian converts, the Goldsmid brothers instead styled themselves 'merchants', but practised as brokers without a licence.⁸⁷ More importantly, Ricardo was able to stand and be elected a member of parliament in 1819.⁸⁸

The issue became a controversial one within the Goldsmid family when Alexander's cousin, John Louis Goldsmid, converted to Christianity, and sat with William Wilberforce on the committee of the London Society for Promoting the Knowledge of Christianity among the Jews. Alexander Goldsmid told Perceval that he had been confined on this occasion by his wife ('...who got the start of him "otherwise," said he, "I was about to confine her."'') - evidently untruthfully, since the admissions register listed him as a widower.⁸⁹ However, he also told Perceval that on a previous occasion he had been confined because of '...differences with his partners, and...his religious opinions; for he is a Jew by birth, but of the Protestant persuasion.'⁹⁰ Charles Newington asked Perceval not to lend Goldsmid his New

Testament bible, because '...it excited him'.⁹¹ It is easy to imagine that Alexander's conversion might have caused great conflict with one of the partners and brothers who signed his certificates, Isaac Lyon Goldsmid (1778-1859), who was actively involved in lobbying for the Jewish Disabilities Bill, which had been thrown out of the Commons in 1830, but was to reach the House of Lords in the reformed parliament in 1833.⁹²

What is unclear - assuming that this was not simply a case of wrongful confinement - is with how much therapeutic optimism Isaac Lyon Goldsmid agreed to Alexander's transfer to Ticehurst from single care in May 1832. If John Perceval was accurate in believing the dangers of public exposure to be greater from confinement in a private asylum than in single care, then a belief in the greater therapeutic value of the asylum care might explain the Goldsmids' willingness to take that risk.⁹³ Isaac Lyon Goldsmid had an interest in Utilitarianism and radical social reform: he was a founder member of the London Athenaeum, and one of his largest benefactions was a gift of money to help purchase the site for the non-sectarian University College London. As an admirer of Robert Owen, Goldsmid evidently believed in the malleability of human nature through social organization. According to Owen's autobiography, Goldsmid and his wife had:⁹⁴

...trained and educated a family of eight, as nearly according to the system of New Lanark, as a conscientious adherence to the Jewish religion would admit.

However, Perceval documented only Charles Newington's assertion that Alexander Goldsmid wanted 'more society' than he had had in single confinement as a reason for the change.⁹⁵ Ultimately, Alexander's own world-weary disdain for recovery proved an accurate prognosis: he was discharged 'not cured' in August 1842, and died in the following year.⁹⁶

Undoubtedly, if Isaac Lyon Goldsmid had ever visited Ticehurst (and there is no evidence to say whether he did or not), he would have found himself out of temper with Charles Newington, whose politics were less radical, and whose techniques of moral management were more disciplinarian than those advocated by Owen. Poll-books for 1832 and 1837 show that Charles Newington voted for independent candidates who held conservative opinions on everything except increased representation: against Catholic emancipation, for the Corn Laws and against free trade.⁹⁷ An aside in his paper on force-feeding noted that the instrument he had devised might also be useful '...in the administration of medicine to refractory children'.⁹⁸ The morally tutelary attitudes he adopted towards his employees have already been documented.

This emphasis on moral improvement, as well as the high

evaluation of a warm and cohesive family life evident in George Newington's letter, are, given the family's Anglicanism, suggestive of some Evangelical influence on Charles Newington's values. His generosity towards poorer patients, which was never allowed to expand to the reckless proportions of a bad business sense, implies a preoccupation with probationary acts of benevolence which was characteristic of Evangelicals who painted on the narrow canvas of private business, rather than a broad canvas of political and social reform. The provision of a pew for patients in the parish church, as well as a chapel in the asylum, both suggest a more central concern with religion than Charles' father Samuel possessed. Stained-glass windows of the four evangelists and four prophets in Ticehurst parish church were erected to commemorate Charles and Eliza Newington.⁹⁹

Personally, Charles Newington was described by his obituarist as 'nervous and sensitive'.¹⁰⁰ John Perceval's account of him confirms this - Perceval wrote that Newington 'never spoke three sentences together...on any disputed question, without stammering'.¹⁰¹ For the last two years of his life Charles Newington suffered from tic doloreux.¹⁰² Yet the same obituarist also described his subject as 'resolute where action was imperative', and certainly Newington was firm in not allowing Perceval to travel to London, or even to

Tunbridge Wells. Perhaps understandably, Perceval saw this professional self-confidence as 'erroneous conceit', arguing that Newington was 'a coxcomb about his ideas of treating his patients'. Whether or not Charles Newington's self-confidence was as steeped in vanity as Perceval suggested, it was bluff enough for him to inform the inspirationally infatuated Perceval that, given the opportunity, he would have had no hesitation in treating Ezekiel as insane.¹⁰³

This mellows the zeal of Charles Newington's religious countenance, as it sharpens that of his professional one. Similarly, his acceptance of dissenters as patients - like the Unitarian Martineaus, and the Methodist Stephen Dickenson¹⁰⁴ - as well as his unproselytizing treatment of Alexander Goldsmid, suggest a pragmatic religious tolerance. His benevolence towards patients, his benefactions to the local church, and his assumption of a role as moral guardian to his employees, also had older and more secular roots than Evangelicalism - and new social aspirations - in the traditional paternalism of the landed gentry.

Perceval described Charles Newington as rather snobbish, claiming that he 'seemed to think it a feather in his cap to have one of my name in his asylum'.¹⁰⁵ The continuous improvements to the grounds and main building can also be

taken as evidence that Charles Newington was eager to better his social standing. In the early 1830s, apart from the chapel, two new wings were built on to the asylum, and a covered walkway - the 'Chinese Gallery' - in which patients could exercise on wet days, was constructed and decorated with black oak which had been excavated at Burwash.¹⁰⁶ By 1835, the buildings and grounds were sufficiently lavish to fill more than six pages of Thomas Horsfield's coffee-table county history of Sussex, including two full-page engravings of the Highlands and the Chinese Gallery.¹⁰⁷

This was class, but it was also advertising. Horsfield wrote that:¹⁰⁸

At Highlands in this parish there is an establishment for the reception of insane persons, the inmates of which are of the highest class.

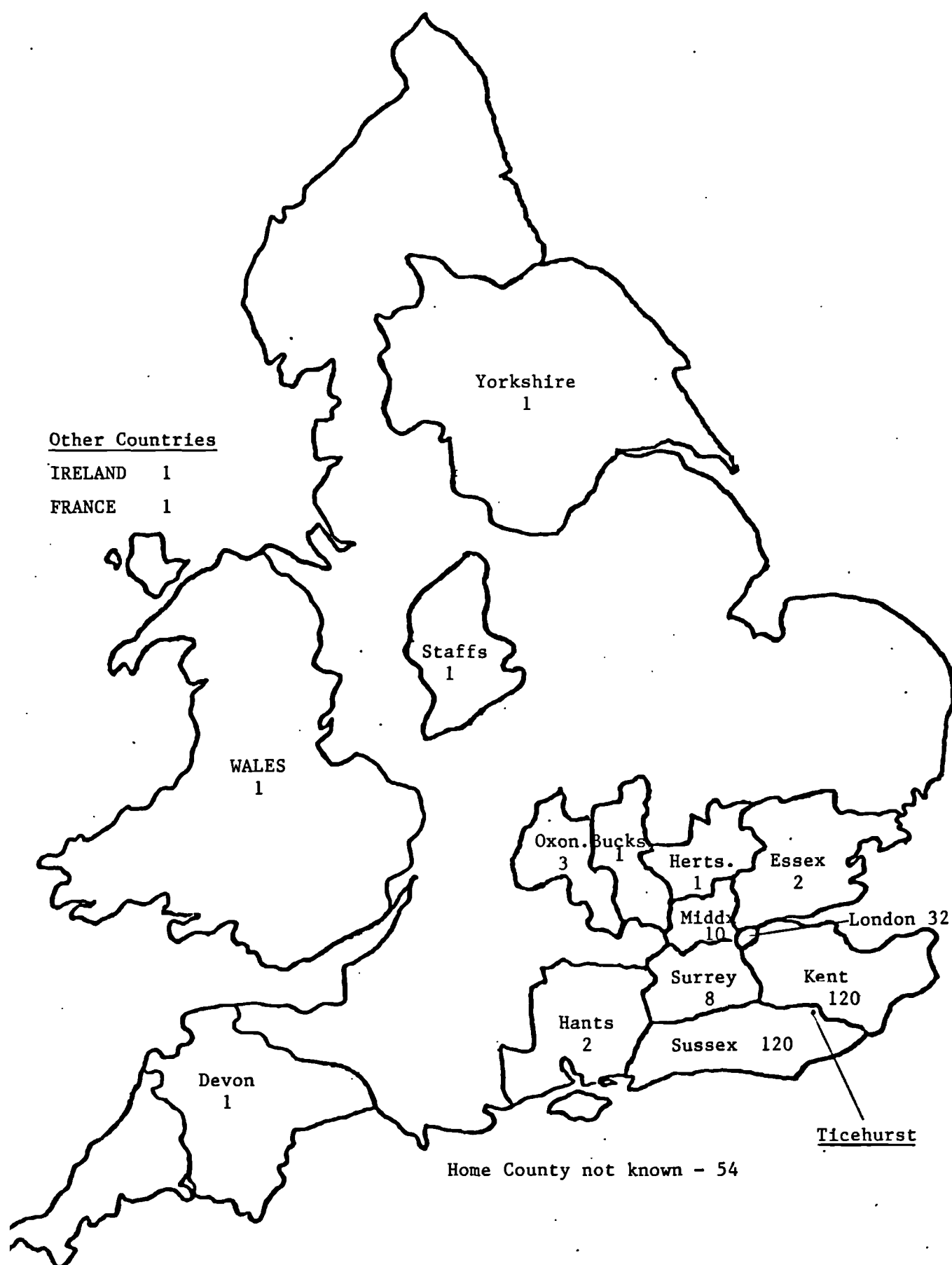
Admissions to the Highlands - which was only licensed to take four patients in 1830 - were indeed almost exclusively upper-class.¹⁰⁹ However, an analysis of the former occupations of first admissions to Ticehurst Asylum between 1 August 1817 and 31 July 1845 shows a wide social range - from baronets to domestic servants - but suggests about two-thirds of first admissions were middle-class (see Table 16).

Unfortunately, these statistics represent only about one

third of male first admissions, and one fifth of female first admissions. In addition, many female patients' marital status is listed as their 'former occupation', with no indication of their social class. A closer focus on first admissions between 1 August 1827 and 31 July 1832, for which information is available for more than three-quarters of male first admissions, and over half of female first admissions, suggests the professional and commercial middle-class, and tenant farmers, continued to form the majority of new admissions to Ticehurst up until the early 1830s (see Table 16.1). It would make sense for the proprietor of an asylum like this to feel that his reputation might be enhanced by the admission of a former prime-minister's son.

However, after 31 July 1832, the median length of stay for first admissions increased from under six months to over one year (see Table 17). The median length of stay for patients resident in the asylum had been rising steadily since 1815, but plateaued from 1830 onwards at 20 - 35 years (see Table 18). Despite the increased accommodation provided by the new wings, and a rise in the number of patients resident in the asylum, the admission rate continued to fall steadily (see Tables 12 and 13). The sharp increase in fees charged to first admissions after 31 July 1832 suggests Charles Newington was able to be increasingly selective in his choice of

Figure 7: Countries and Counties of Origin of First Admissions, 1817-42



patients. Although details of former occupations of first admissions are available for less than half first male admissions, and less than one third of first female admissions between 1 August 1832 and 31 July 1845, those which are known reflect an increasing proportion of upper-class admissions (see Table 16.2).

Most first admissions throughout this period continued to come from Sussex and Kent, but the change in the social composition of first admissions to the asylum was paralleled by an expansion of the geographical area from which they were drawn (see Figure 7 and Table 19). Despite the decline in the admissions rate, this suggests a widening reputation which would have further enhanced Charles Newington's freedom to be selective in the patients he admitted. People travelled from as far away as Yorkshire, Wales, Ireland and France to become patients at Ticehurst.¹¹⁰

With the ending of pauper admissions, and the expansion of the geographical area from which private patients were drawn, any correlation between the asylum's admissions rate and an estimation of existing need or demand within the counties of Kent and Sussex becomes increasingly tenuous. As before, no simple correlation existed between the size of towns and parishes in Sussex and Kent and the number of patients they sent to Ticehurst Asylum

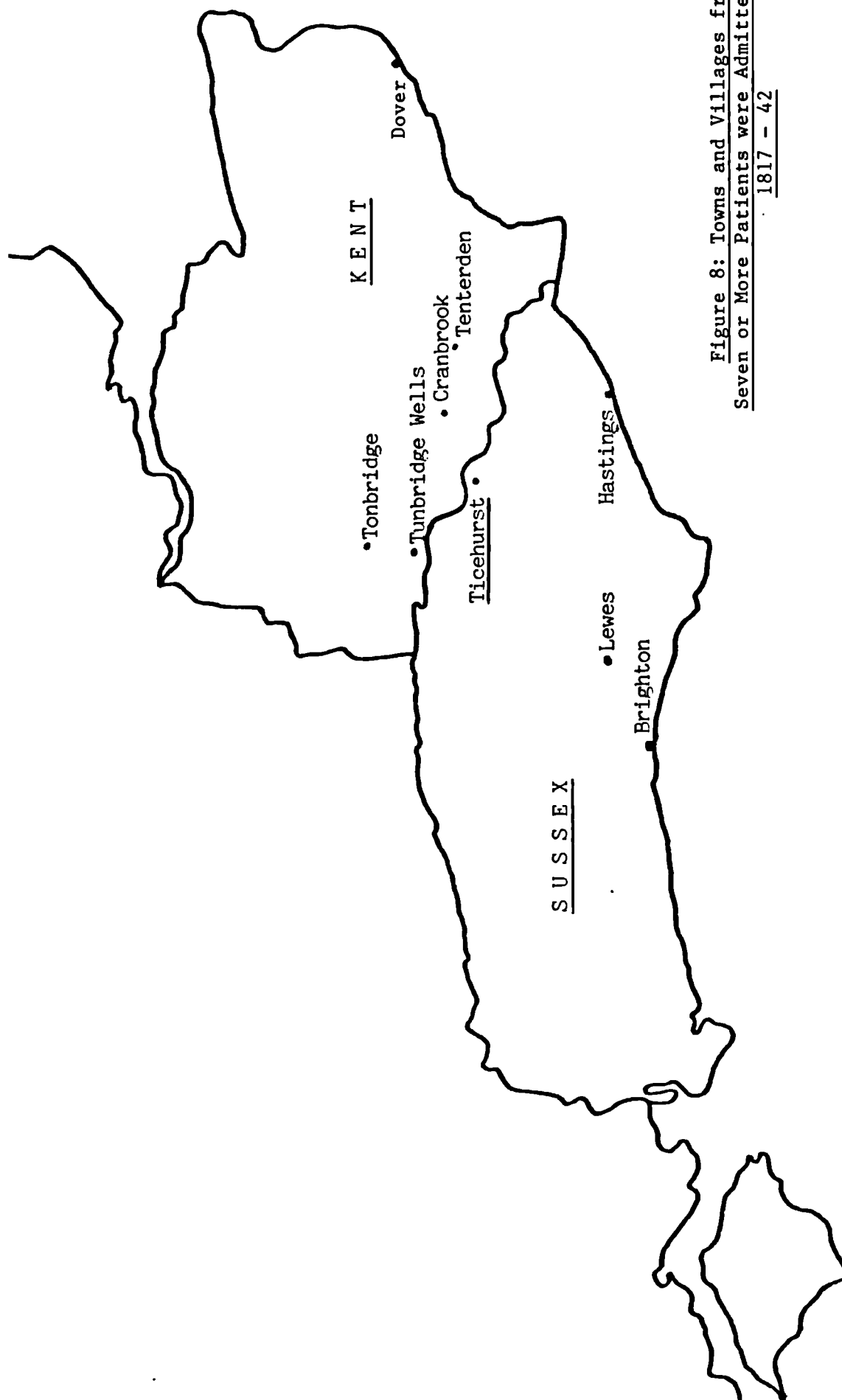


Figure 8: Towns and Villages from which
Seven or More Patients were Admitted to Ticehurst,
1817 - 42

(see Table 20). However, there was a striking decline in the proportion of first admissions who came from small villages in the immediate vicinity of Ticehurst in favour of more distant and commercial centres, most notably Dover (see Figure 8). The only exception to this general trend was the hamlet of Pembury. However, the six admissions from this village included three Dickensons, two of whom may in fact have been the same patient, although the accounts do not specify whether 'Mr Dickenson's' second admission was a readmission or not.¹¹¹ The growth and gentrification of Tunbridge Wells in this period is reflected in an increase in the proportion of first admissions who came from there (see Table 20). Towards the end of the period covered by this chapter, in April 1840, Samuel Wilmott Newington, Samuel Playsted's son, opened a small private asylum at Goudhurst in Kent called Tattlebury House, which henceforward shared the Kentish private asylum clientele.¹¹²

Throughout the 1820s, the only doctor who is known to have referred more than one or two patients was Thomas Mayo. Most of the ten patients whose certificates he signed between 1819 and 1833 were high class, and high fee paying. They included David Martineau, and Sir William Walter Yea. In addition, these patients stayed longer than was average for first admissions: eight of

them stayed for more than ten years, and four of these for more than thirty years.¹¹³ Although Thomas Mayo's involvement in the certification of patients was clearly contrary to the spirit, although not the letter, of the 1828 Madhouses Act, which sought to make it illegal for doctors with an interest in a private asylum to certify admissions to that asylum, Mayo certified three more admissions to Ticehurst after the passing of the Act, and before he left his appointment as visiting physician in 1835.¹¹⁴

The nature of Thomas Mayo's involvement in the treatment of patients at Ticehurst needs to be elaborated. From what has been said so far, it might be possible to infer that some tension existed between Thomas Mayo's advocacy of a strongly medically-based therapy, and Charles Newington's pursuit of moral-therapeutic fashionability through the elaborate ornamentation of Ticehurst's grounds. However, later medical writings by Thomas Mayo suggest that his experience in practise at Ticehurst and elsewhere substantially modified the extreme heroicness of his first publication, and persuaded him that moral therapy could be both effective and desirable.

The title of Mayo's Elements of the Pathology of the Human Mind (1838) made clear this change of position. In terms of medical treatment there were two striking

changes in Mayo's argument: firstly, a new caution about chronic depletion; and secondly, in the absence of depletion, a new reliance on sedatives. Although Mayo still argued that the plethoric inflammation of the brain found in insanity indicated that blood-letting could be beneficial, he now cautioned that the expected advantages from depletion should be weighed against how exhausted the patient was by the disease. Telling a cautionary tale of a patient in 'an establishment' whose condition dramatically worsened after leeches were applied to her temples, Mayo argued that patients of a sanguine or bilious temperament could generally withstand more blood-letting than patients of a nervous or serous temperament. Whilst patients of a serous temperament required moderate depletion through the application of counter-irritants, patients of a nervous temperament required tonics.¹¹⁵ In practise, this distinction reads as remarkably close to Nesse Hill's distinction between sthenic and asthenic patients which Mayo had repudiated in 1817.

In 1838, Mayo still strongly recommended the routine use of purgatives and nauseants to decongest the system, although he now advised greater moderation in the use of purgatives on patients of a nervous temperament. The specific drugs he mentioned were different from those which he had formerly recommended: in 1838 he praised

colocynth rather than aloes and calomel as a purgative; and ipecacuanha as well as tartrate of antimony as a nauseant.¹¹⁶ In place of the strong narcotic stramonium, and belladonna, which John Mayo had found counter-productive, Thomas Mayo recommended the use of a more mild mixture of digitalis, camphor and potassium nitrate, as well as a mixture of extract of lettuce, camphor and colocynth - the purgative in the latter instance being included to counteract the depressive effect of sedation. Only extract of henbane (*hyoscyamus*) was recommended for its sedative properties in both texts; whilst opium was proscribed in both.¹¹⁷ Thomas Mayo's continuing resourcefulness and openness to experimentation (as well as his willingness to learn from folkloric tradition) was also evident in his high evaluation of the sedative properties of a local Kentish remedy: tincture and infusion of hops.¹¹⁸

There is insufficient evidence to document the extent to which these various remedies were employed in practise at Ticehurst. One plausible argument might be that increased sedation was associated with a substitution of chemical for mechanical restraint, as well as more moderate depletion. However, Anne Digby has also documented an increased use of sedation at the Retreat during the second quarter of the nineteenth-century, the beginnings of which preceded a decrease in the Retreat's

already very limited use of mechanical restraint, in the wake of the non-restraint movement in the 1840s and 1850s. In particular, in the 1830s Thomas Allis introduced a combined sedative and nauseating pill (of morphine and tartrate of antimony) which was used in place of more aggressive vomitives.¹¹⁹ Although by the 1850s there was widespread concern that nauseants like tartrate of antimony were used primarily as a method of chemical restraint, Thomas Mayo's preference for milder sedatives than opium, and concern to counteract the depressive effects of sedation, suggest a desire to leave tranquillized patients mentally alert enough to co-operate actively with moral therapy, whether or not they were physically restrained.¹²⁰

Central to Mayo's understanding of how moral therapy worked, and vital to the preservation of a concept of free will within a psychogenetic theory of mental disorder, was the belief that the patient could play an active role in their recovery.¹²¹ Mayo's first published discussion of the psychology of mental disorders was in an article on 'Insanity and its Moral Preventive' in the first edition of the London Review in February 1829. This appeared alongside Edwin Chadwick's article 'On a Preventive Police' which inspired Jeremy Bentham to ask Chadwick to become his successor, and became a blueprint for the new police force then being introduced into

London by Sir Robert Peel.¹²² Mayo's article argued for a strong enforcement of the law in cases of crimes committed by lunatics, since he believed that the insane could know what was illegal and fear punishment even when they were incapable of making a moral distinction between right and wrong.¹²³

Although Mayo's penal philosophy was utilitarian, his psychology was so only in a limited sense, since for Mayo a mental state in which the will was so weakened or absent that the mind was governed by the pursuit of pleasure and avoidance of pain was symptomatic of moral depravity and insanity.¹²⁶ In 1829, Mayo called this 'insanity of the heart' rather than 'moral insanity', but it was clear that the organic location was intended no more than metaphorically. What his choice of phrase made clear was the influence of Evangelical writings on his ideas: Mayo's sense that emotional disorders were caused by 'viscious motives' which ought ideally to be restrained through self-control was close to the Evangelical emphasis on the need for a constantly vigilant 'religion of the heart' to prevent moral collapse into a naturally sinful condition.¹²⁵

Like Mayo's metaphorical use of 'heart' in this context, the classical humoral tradition of temperaments provided a language in which to express a common-sense bridging of

Cartesian metaphysics. However, in an 1831 Essay on the Influence of Temperament in Modifying Dyspepsia or Indigestion, Mayo felt that it was advisable to spell out that in describing the interdependence of mental and physical states, he was only being softly determinist, since if:¹²⁶

...a given bodily state is followed by a corresponding mental state...the arranging and ordering our body, so that it may best assist our moral and intellectual energies involves a part of our probationary duties.

In a later essay, Mayo argued that it was also the duty of parents and educators to 'counteract or modify' temperament. Using Aristotle's argument that people were accountable for actions which spring from deeply-seated habits, even when these affected their freedom of will, he suggested that the morally insane were culpable, and should be sent to the penitentiary 'in the way of education'.¹²⁷ Mayo was thus unwilling to allow the concept of emotional disorder to become grounds for a blame-free status before the law, as Prichard was prepared to let it become in his now classic description of 'moral insanity' in 1835.¹²⁸

Like his plea in 1817 for heroic medical treatment in cases of insanity, the thrust of Mayo's 1834 Essay on the Relation of the Theory of Morals to Insanity was towards a more active and interventionist role for medicine.

However, the emphasis was now on prevention rather than cure. Seeking to marry the medical profession's responsibility for insanity to widespread middle-class concern with moral reform, Mayo advocated the incarceration of the morally insane who had not committed crimes in new, reforming institutions, 'between a well-regulated school and a madhouse'.¹²⁹ Although one of Mayo's descriptions of the morally insane was of two middle-class men - one of whom could not be certified under existing legislation because he was simply 'profusely extravagant...stern...violent... [and] utterly unjust', but the other of whom was certifiable because he also heard voices - most of Mayo's examples were drawn from the upper-classes and aristocracy. In the late eighteenth and early nineteenth centuries the morally self-critical writings of the Clapham Sect - most of whose wealth came from mercantile and financial capital - had called on the aristocracy to join them in giving moral leadership to society; but by the 1830s the widespread middle-class appropriation of their initiative had engendered a predominantly middle-class critique of the extravagance, injustice and irreligion of the aristocracy, of which Mayo's writings on moral insanity may be seen as part.¹³⁰

A suggestive historical comparison might be the reform of Rugby school carried out by Mayo's college contemporary,

Thomas Arnold. Indeed, it was partly to mop-up those who had been expelled from the newly-reformed public schools that Mayo believed new institutions were needed.¹³¹ As at Ticehurst, fees at Rugby were increased in the early-1830s to exclude the children of local families, and attract a more affluent, upper-class clientele. Just as John Chandos has argued some pupils at Rugby responded to Arnold's moral surveillance of his social superiors as 'dishonourable prying', John Perceval bitterly resented his letters being opened and read at Ticehurst and Brislington House:¹³²

For by what right can a doctor presume to pry into the secrets of a patient's conscience, who is not only a perfect stranger to him, but also a gentleman.

Yet clearly the ethos of moral improvement generated at Rugby School, and purveyed in the writings of Thomas Mayo, was one which resonated with the perceived needs of families who sent their children to Rugby, or referred their mentally disturbed relatives to Thomas Mayo.

Despite broad similarities in the social needs they appealed to, there were significant differences in the philosophies and practice of Mayo and Arnold. Whilst Arnold found it '...very startling to see so much of sin combined with so little sorrow' in the behaviour of his pupils, Mayo argued more naturalistically that individuals who were lacking in moral sense experienced

less conflict over their immoral actions than those with larger consciences.¹³³ Indeed, Mayo explicitly criticised theories of education which were based on a belief in a universal moral sense. However, this was not because he accepted utilitarian arguments for the post-natal formation of conscience through association. For Mayo, the belief that some people who had been given opportunities for moral learning nevertheless failed to acquire a moral sense was evidence that they lacked an innate moral potential; and he argued that to accept such a lack in some instances compromised 'our belief in the general law' of free will less than the idea that the morally insane were weak-willed.¹³⁴ In 1838, he drew an analogy between the 'destitution of principle' found in such individuals, and the absence of intellectual capabilities found in Idiocy, and suggested, contrary to his earlier opinion, that what he now called 'Brutality' could not properly be regarded as a form of insanity, which implied only 'perversion of tendencies and want of self-control'.¹³⁵

In the absence of moral sense, a rigorous and vigilant authority could only hope to instil morally indiscriminating habits of good behaviour. Thus although Mayo described 'A high and enlightened religious feeling' as the prime moral preventive of insanity, he believed 'the motives and sanctions of revealed religion' to be

beyond the comprehension of those who had no conscience, and therefore that religious instruction would be wasted on 'Brutal' patients.¹³⁶ This disdain for an empty pursuit of the forms of religion in the absence of moral understanding also confirms the influence of Evangelicalism on Mayo, with its distinction between 'real' and 'nominal' Christianity.

The only case Mayo described in detail from Ticehurst where an absence of religious observance was made explicit was of a 'Brutal' boy - 'N.B.' - whom it was unfortunately not possible to identify from the accounts; and, given the role of religion in John Perceval's mental disorder, the unfinished state of the chapel whilst he was a patient, and the fear that he would attempt to escape if allowed to leave the asylum grounds, Charles Newington's refusal to allow Perceval to attend Ticehurst parish church cannot be taken as evidence of a general repudiation of the value of religious observance to moral therapy.¹³⁷ Indeed, the construction of a chapel suggests that Charles Newington was concerned to enable patients who were not considered self-controlled enough to attend parish services to be given an opportunity for religious observance. However, since in practice it proved difficult for Ticehurst to secure the regular services of a chaplain for some years after the chapel was completed, it is clear that the chapel at Ticehurst

played a far less central role in the life of the asylum than Arnold's pulpit did at Rugby School.¹³⁸

The sanctions with which authority was backed up at Ticehurst and at Rugby were different too. In keeping with the utilitarianism of Mayo's penal philosophy, corporal punishment of the type practised at Rugby was ruled out as a means of control. The sixteen year old boy 'N.B.', whose treatment Mayo supervised at Ticehurst, was attended by two men who were instructed to use force to ensure obedience, but not such as would cause 'the slightest bodily pain'. At other times 'N.B.' was intimidated with the threat that he would be put in a strait waistcoat, but this was never actually done. Mayo believed the reality of confinement and close supervision deterred resistance; he described 'N.B.' as 'tranquillized by his utter inability to resist'.¹³⁹ Ultimately, the doctors' and attendants' power stemmed from the patients' desire for release: an inverse image of the threat of expulsion through which boys were manipulated at Rugby School.¹⁴⁰

In many respects, the moral therapy advocated by Mayo conformed to what is known of the moral treatment practised in other early nineteenth-century institutions for the insane. Tuke's Description of the Retreat also emphasised the value of the patient's separation from

their home surroundings in providing an incentive for recovery.¹⁴¹ Mayo's recommendation of the importance of gaining psychological ascendancy over the patient through irresistible force rather than violence, as well as his advocacy of seclusion and a minimal use of restraint conformed to practise at the Retreat. Although far greater emphasis was placed on religious observance at the Retreat, Anne Digby has recently suggested that the Quaker asylum was unusual in this respect.¹⁴² Like Tuke, Mayo advocated the value of exercise, varied objects of amusement, and purposeful activity or work to the patient's recovery.¹⁴³

With logical consistency, Mayo had argued in 1829 that morally insane patients needed to be treated with authority rather than through appeals to their desire for approbation, since such desires formed part of the moral sense Mayo believed these patients lacked.¹⁴⁴ However, in his case-history of 'N.B.', Mayo noted the beneficial effect of praise in slowly cultivating the 'desire for esteem' which Tuke had seen as central to moral management. In addition, Mayo described the operation of a psychology of reward and punishment which was similar to that practised at the Retreat: 'N.B.' was encouraged to correspond with Mayo, but if he sent a letter which was 'insolent or wayward', his next letter would be returned unopened. The threat of mechanical restraint,

the incentives of greater freedom within the establishment (such as being invited to dine with the Newingtons), and ultimately of release, also formed part of this disciplinary framework.¹⁴⁵

Although Mayo adopted a tutelary role in relation to his patients, and one which he compared to education in schools, he never explicitly compared the insane to children in the way that Samuel Tuke did. However, the very limited evidence there is of actual practise at Ticehurst suggests attendants there may have been encouraged to treat their charges as wayward children. Thus John Perceval was deeply affronted when the head attendant at Ticehurst, Robert Hervey, encouraged him to drink his medicine because it was a pretty colour; an event which led him to reflect scornfully that:¹⁴⁶

If a lunatic will but be a good child, and do what its doctor bids him, and let its servants put on its gloves for him, and allow them to be its directors, and love its mamma, and stay in prison as long as its mamma and its doctor desire it, it may be allowed at last to come out of sound mind! but manliness, independence and self-respect, do not enter into the doctor's predicament of sanity, they are inconvenient.

This would suggest that attendants at Ticehurst sometimes failed to observe the distinction Tuke made between treatment which was appropriately protective and nurturing, and treatment which was inappropriately condescending and belittling.¹⁴⁷ Like Tuke, Mayo

emphasised the importance of treating the patient both protectively and with respect. Yet each focussed on opposite aspects of this commonly perceived dual role. Thus Tuke stressed the therapist's ultimate answerability to God for unnecessarily harsh treatment of their vulnerable charges; whilst Mayo argued that it demeaned human nature to neglect moral therapy in favour of physical treatment.¹⁴⁸ Consequently, Mayo highlighted the importance of the face-to-face relationship between physician and patient, as much as the techniques of moral management outlined above.

For Mayo, the psychological path to recovery lay in increasing the patient's emotional flexibility and resilience. He suggested that the physician should steadfastly refuse to confirm or deny the patient's delusions, but at appropriate moments ('tempora fandi') should point out contradictions in what the patient said.¹⁴⁹ Equally, he stressed the importance of refusing to be provoked to anger by the patient, since he believed a neutral response would erode the satisfaction the patient derived from their behaviour. This 'studied indifference' has much in common with later nineteenth-century approaches to the treatment of disorders which were seen as primarily accessible to psychological treatment, notably hysteria.¹⁵⁰ In addition, Mayo argued that the patient should be taught

to curtail their pleasure and enjoyment before it became too nervously exciting, and to accustom themselves to the inevitable recurrence of sad and painful feelings. The process by which this therapeutic change could be accomplished was the 'law regulating the influence of sympathy that the weak should take their tone from the strong'. Treated with firmness, but also with kindness, Mayo believed the patient could develop internal strength.¹⁵¹

Like Tuke, Mayo argued that the way to elicit trustworthy behaviour was to treat the patient with trust. To 'N.B.' Mayo emphasised the contractual nature of the bond between patient and physician: the restraint imposed on the patient would be inflexible until the patient learnt self-control, at which point 'strict justice will be done him, upon the terms originally stated to him'.¹⁵⁴ Yet Mayo's self-presentation as a man who was guided by reason needs to be critically read. He described his response to a patient who announced his recovery to Charles Newington after nearly three years in Ticehurst in these highly rational terms:¹⁵³

I went over to Ticehurst, and formally stated to the patient, that I accepted with pleasure his announcement of his recovery; that nothing more remained, than that he should give himself and me some proof of the soundness of his own impression by spending a portion of time which I named, at the establishment. This patient never relapsed.

Yet Perceval's account of Mayo's response to his appeals for a transfer to single care suggests that - although Mayo certainly presented himself to his patients as open to persuasion - in practise he was guided by Charles Newington's opinion of a case, and observed his patients with a less open mind than his writings imply.¹⁵⁴

In other respects, Mayo acted with great moral self-confidence in assuming the right to take decisions about his patients. Thus although 'N.B.' was considered neither insane, nor an idiot, and therefore fell outside the ambit of the lunacy laws, Mayo was candid about how he had persuaded the magistrates to allow 'N.B.' to be confined because he lacked 'self-control'.¹⁵⁵ Perceval's impression, not only that Mayo was 'too much the ally of Mr Newington', but that he intervened to discourage the magistrates from paying serious attention to Perceval's desire for transfer to single care, thus gains plausibility from Mayo's own account of his behaviour in 'N.B.'s' case.¹⁵⁶ Alongside the moral contract which Mayo described as existing between patient and doctor - that the patient could regain their liberty through co-operating fully with their treatment - there was also a less clearly articulated understanding to be reached between the physician or superintendent of the asylum in which a patient was placed, and the patient's family. Thus it was 'N.B.'s' father who consulted Mayo on how he

should manage his son; and to Mayo that Perceval's mother wrote for advice on how she should respond to her son's request to be transferred to single care.¹⁵⁷ Since it was the patient's family who paid the physician's fees, it was primarily they, rather than the patient, whom the treatment had to satisfy.

As for the first twenty-five years of its operation, most patients in the 1820s and 1830s were referred by a close relation, and predominantly by men (see Table 21). Beyond the assumption of this clearly-defined legal responsibility, other members of the family could play an actively solicitous role in monitoring the patient's treatment: thus although Perceval's certificates were signed by his eldest brother, his mother corresponded regularly with him and with his doctors.¹⁵⁹ Some information is available on the kind of behaviour which led to confinement: Perceval suffered from aural hallucinations; 'N.B.' had threatened one of his teachers with a knife, and (although three years prior to his confinement) exposed himself to his sisters; the surgeon and horticulturist Joshua Mantell (1795-1865), who became a patient at Ticehurst in the mid-1830s suffered from 'déjà vu' after being thrown from his horse, and became irritable and angry with his family and servants.¹⁶⁰ What is missing is the process of internal decision-making by which families decided to try asylum

care.

The role played by doctors who referred patients is largely obscure in this period. One possibility is that copies of the prospectus were sent to physicians with a special interest in mental disorders, in the hope that they would refer patients to Ticehurst. Certainly, from the early 1830s, several patients - including Alexander Goldsmid - were referred by Alexander Robert Sutherland (1782-1861), the physician at Saint Luke's who also had an extensive private practise of patients in single care. However, Sutherland was the only physician apart from Mayo who is known to have referred more than two patients to Ticehurst in this period.¹⁶⁰

The problem of why families chose to send patients to an asylum rather than caring for them at home, or placing them in single care, is highlighted when it is considered that in the 1830s public confidence in the medical profession was at a low ebb.¹⁶¹ As in the case of the Goldsmid family discussed above, it is difficult to know whether asylum care was seen primarily as a means of relieving the family of a difficult member, or providing companionship for the patient, and with how much therapeutic optimism patients were confined. High standards of physical care, and the doctor's own confidence in his abilities could help alleviate the

guilt and helplessness experienced by families who no longer felt able to cope with a mentally disturbed relation. Mayo's confident assumption of a paternalist role in relation to his patients relieved families of the responsibility of caring, and taking decisions, for them.

Medically, Mayo secured the broadest possible audience through eclecticism and openness to new ideas. Thus, although he was eager to dissosciate himself from phrenology's politically radical exponents, he suggested that the localization of conflicting attributes in the brain of one individual (such as benevolence and destructiveness) offered important insights into the fundamentally conflicted character of human nature.¹⁶² Similarly, although Thomas Mayo never gave mesmerism the vociferous and whole-hearted support which eventually led to his brother Herbert's relegation from the ranks of medical respectability, like James Cowles Prichard he believed some therapeutic potential - particularly in the treatment of hysteria - might emerge from further investigation into double consciousness, whilst firmly repudiating materialist explanations of how animal magnetism worked.¹⁶³ The presence of such a broad-based approach in practice at Ticehurst, as well as high standards of physical care, gave the asylum widespread appeal. It made it possible, for example, for the homeopath and phrenologist John Epps (1805-69), who

visited Joshua Mantell in Ticehurst in March 1836, to be completely satisfied with the care his former student and friend was receiving, whilst he pondered the role played by Joshua's large 'organ of individuality' in the case.¹⁶⁴

As in the case of 'N.B.', there is no trace of Joshua Mantell's admission in the accounts: the first entries in his name were made in 1839.¹⁶⁵ It therefore seems likely that both these patients were initially admitted to the Highlands, the records for which are less complete. The introduction to Epps' diary described the circumstances in which Mr and Mrs Epps saw Joshua in this way:¹⁶⁶

They found him seated in a large, comfortable room, by a good fire, with his books and papers about him. He was delighted to see his old friend, with whom he had a long talk concerning the botany of the neighbourhood, and on other subjects of mutual interest, one of which was a book Joshua said he was about to publish.

The Epps were later told that Joshua's talk of publication was delusional, but the impression of a warm and cheerful domestic ambience at the Highlands echoed Perceval's depiction of the Asylum.¹⁶⁷ Indeed, patients at the Highlands lived more intimately with the Newingtons, and were invited to share meals with the family as their condition improved. Even in the Asylum, a genteel ethos underplayed the institution's confining

role by, for example, concealing bolts on the doors behind panelling, in a way which may have reassured the families and friends of patients - as well as some patients - through its simulation of an ordinary domestic environment.¹⁶⁸

Statistics of Ticehurst's cure, discharge and death rates did not become available to families or physicians until the publication of the first government statistics in 1844.¹⁶⁹ Whilst the cure rate these presented of over 50% was comparable to other highly regarded asylums like the Retreat and Brislington House - and at slightly less than 15% the death rate was noticeably lower - these statistics differ considerably from those calculated from Ticehurst's records (see Table 22). Although slightly fewer cases were included in the official statistics than are listed in the accounts, most of the discrepancy between the recovery rates could be accounted for by the number of patients whose condition at discharge was not listed in the accounts. However, a closer focus on the period 1 August 1817 - 31 July 1842, for which the condition at the end of treatment is available for two thirds of first admissions, still reflected a lower recovery rate than those calculated by Parry Jones at Hook Norton and Witney in Oxfordshire, and by Anne Digby at the Retreat (see Table 21.1).¹⁷⁰

The difference in death rates between Hook Norton and Ticehurst was negligible: yet the death rate at Ticehurst cannot be accounted for by a predominance of pauper patients in poor physical health, as Parry-Jones accounted for the relatively high death rate at Hook Norton. Unlike the high proportion of deaths within four weeks of admission noted at Hook Norton, most of those who eventually died in Ticehurst stayed longer than the median length of stay for first admissions.¹⁷¹ Arguably, the high death rate at Ticehurst - or more accurately, the lower rate of removal and transfer - despite relatively high and increasing fees reflected a high level of satisfaction amongst Ticehurst's clients, which had nothing to do with the asylum's capacity to cure. This hypothesis is confirmed by the presence of a fairly low rate of removal or transfer, and very high death rate, at the highly reputed Retreat.¹⁷² Seen from this perspective, the increasing length of stay at Ticehurst becomes a measure of the asylum's success in the eyes of its client population.

As Anne Digby has argued in connection with the development of public asylums in eighteenth-century England, there is a lack of fit between the predominantly bourgeois clientele of the asylum, and recent historical explanations for the growth and success of the asylum movement by Foucault, Doerner and Scull.¹⁷³ These models

all in different ways see the development of specialist institutions for the insane as targeted primarily at the idle and insane poor - containing elements of social disorder, freeing patients' families to meet new demands to sell their labour outside the home, and purveying a bourgeois system of values in which work was associated with rationality, and idleness and poverty with madness.¹⁷⁴ Yet there is a sense in which the growth of private asylums can be linked to the development of a market economy: not as Scull argues for public asylums through the undermining of a traditional home-based care for the insane, but as part of the growth of services to meet the requirements of a newly affluent and leisured middle class.¹⁷⁵ What needs to be elaborated in view of the asylum's limited capacity to cure are the social needs which these institutions fulfilled.

The concept of a decline in community tolerance, not only in the sense of a decline in familial systems of practical care, but in the sense of an increased fear of bizarre behaviour because of the development of larger communities in which people were more frequently strangers to each other, has been linked to the impact of industrialization in creating newly urbanized centres of population.¹⁷⁶ Yet of greater importance to the expansion of private asylums in the early nineteenth century was the success of the Evangelicals

self-conscious attempt to radically alter accepted standards of behaviour, and reform the manners and morals of the nation. Although moral purity was seen first and foremost in terms of the individual's earnest endeavour to live according to Christian principles, a primary sphere for the display of real Christian virtue was the family. In a world which was seen as morally depraved and in urgent need of reform, home could provide a haven of peacefulness and calm; a small world which could be protected from profanity, frivolity and excess. From this beleaguered perspective, domestic harmony became a crucial index of moral seriousness and respectability.¹⁷⁷

It is one of the paradoxes of the development of private asylums that it was able to occur at a time when middle and upper class families were becoming increasingly insular and defensive. Yet private asylum care was marketed in a way which stressed its fundamental harmony with the best interests of the family. The increasing use of the word 'asylum' rather than 'house' to describe private madhouses as well as larger institutions chimed with a vision of the world outside as hostile, immoral and distracting. Private asylums sought to emulate the cosiness and tranquillity of idealized family life. Although in sending an insane person to an asylum the family's close natural bonds and self-sufficiency were temporarily disrupted, the asylum also offered to protect

the family from the discord, disorder, intemperance and irrationality of mental disturbance. Mayo argued that such a separation was advisable not only because the painfulness of exclusion from the family gave the patient an incentive for recovery, but because the bad feeling aroused in the patient by the necessity for restraint might otherwise permanently damage the harmony of family relations.¹⁷⁸

The extent to which disruptive behaviour came to be construed in moral terms, at least by the medical profession, is evident in the fact that for a time 'moral insanity' became the most frequently used diagnosis at Ticehurst. Between 1 January 1839 and 31 December 1843, almost one third of all admissions were diagnosed as morally insane.¹⁷⁹ Anne Digby has also described a peak in the use of moral insanity as a diagnosis at the Retreat between 1838 and 1855.¹⁸⁰ Tantalizingly, nothing is known of the kind of behaviour which led to such a diagnosis at Ticehurst. What is clear is that asylums with a middle and upper class clientele were able through the use of the diagnosis of moral insanity to appear as part of the apparatus for moral reform; and the emphasis that such reform was primarily a problem of individual transformation from within complemented the socially conservative role of Evangelicalism in suggesting that moral regeneration from within the existing structures of

church and state could mitigate the radical social problems created by industrialization.

It has been argued that despite the Clapham Sect's original appeals to the aristocracy, the most crucial role played by Evangelicalism was in mediating the transition to political power of the industrial bourgeoisie.¹⁸¹ Since access to private asylums was primarily determined by wealth, like public schools they helped to forge a moral consensus amongst different sectors of the upper and middle class. At the Highlands in the early 1840s the arriviste son of a trillionaire Russia merchant or Manchester silk manufacturer could have talked over dinner to two baronets, and the daughter-in-law of the high sherriff of Cornwall; or alternatively to members of the upper professional middle class, like the wife of a royal surgeon and sister-in-law to a former headmaster of Eton, or the brother of Queen Victoria's surgeon-accoucheur.¹⁸² From Ticehurst, patients were encouraged to continue to perform paternalist acts of benevolence to the poor. Thus Revd Chambers gave money to buy beef and bread for paupers in his Parish, and Emily Graham made regular donations to the National Schools.¹⁸³ Mayo noted 'N.B.'s' decision to tip one of his attendants as a significant moral improvement.¹⁸⁴ Whilst the middle class aimed to increase the humanity and benevolence of the ruling élite

to the labouring classes, they also aspired to increase their own political power, and enjoy the traditional privileges of the landed gentry.

For the Newingtons, Ticehurst was a vehicle for upward social mobility. Four of Charles and Eliza Newington's sons went to Oxford or Cambridge; and the two eldest who qualified in medicine became physicians rather than surgeons.¹⁸⁵ In addition, both these sons who eventually succeeded Charles Newington married daughters of local landowners: Charles Edmund the daughter of one of the visiting magistrates to Ticehurst, Revd Richard Wetherell; and Samuel the daughter of an experimental agriculturist and former governor of St Helena, Major Alexander Beatson.¹⁸⁶ The interior of Ticehurst parish church reflects the Newingtons' substantial local standing: apart from a chapel to the Courthope family (several of whom, as local magistrates, were also visitors at Ticehurst), nineteenth-century memorials to the Newington family dominate every wall.¹⁸⁷ Although Thomas Mayo's future career was not so intimately bound up with Ticehurst, it followed the same pattern of a consolidated middle-class position which ultimately aspired to the privileges of the upper class. After acting as president of the Royal College of Physicians during the crucial period of the Medical Licensing Act, Mayo made an affluent marriage to an admiral's widow, and

completely retired from practice.¹⁸⁸

Foucault has seen one crucial aspect of late-eighteenth and early-nineteenth century asylums as the incorporation and promotion of a patriarchal ideology, and bourgeois ideal of the family, which ultimately received its most archetypal expression in psychoanalytic theories of the family romance as an essential process for psychological maturation, and the re-enactment of this process in the relationship between analyst and analysand.¹⁸⁹ Some aspects of Foucault's history loosely fit the Ticehurst example: the simulation of an ordinary domestic environment; Mayo's assumption of a medically paternalist role; the refusal to address the patient's point of view. Foucault saw the substitution of bonds of affection, obligation and guilt for the whips and chains of earlier methods of treatment as more insidiously cruel and repressive.¹⁹⁰ Yet Mayo was unembarrassed by the authoritarian aspects of his role in a way which Samuel Tuke was not; and at least some of Foucault's objections to moral treatment are to what he saw as its disingenuousness when compared to earlier forms of treatment.¹⁹¹

There are several respects in which Mayo's writings could be seen as sharing common features with psychoanalysis: his interest in double consciousness; his sense of human

psychology as essentially conflicted; his focus on crucial opportunities for insight in the doctor-patient relationship which engendered recovery. But these are not aspects of psychoanalysis included in Foucault's history. In fact, if the freedom of patients in asylums were not limited by certification, Mayo's description of the moral contract between patient and physician might read as close to one liberal argument against Foucault's view of psychoanalysis as intrinsically repressive: that it is ultimately a free contract to which both parties consent.¹⁹²

The emergence of a new domestic ideology influenced developments at Ticehurst, both as an ideal to be emulated within the asylum, and in encouraging middle and upper class families to be less tolerant of disruptive behaviour. However, an ideal of home as separate from and more problem-free than the world outside is not intrinsically paternalist. And although the domestic ideology which developed around this polarisation in the late-eighteenth and early-nineteenth centuries relied on the deference of other family members to the father in exchange for his protection, the ways in which paternalism shaped the growth of the asylum movement, in Sussex at least, were more historically complex than Foucault's analysis permits.

As described earlier in this chapter, Charles Newington's obituarist was eager to portray him as a benevolent paternalist: a loving father, a prudent manager, and a generous doctor. By the mid-1840s, there was some truth in the claim that Charles Newington maintained long-stay patients at real cost to himself. The median charge to patients who had been resident for twenty years or more on 1 August 1845 was only two-thirds of the median charge to all patients resident.¹⁹³ Although the accumulation of long-stay patients still guaranteed a core income, the need for such a guarantee was less acute than it had been in the first years after opening. In view of Ticehurst's high status, and the decline in the number of patients Charles Newington was able to admit, the presence of so many low fee paying, long-stay patients reflected a genuine concern for the patients' well-being.

Yet the image of benevolent paternalism was also one with deep social resonance by the 1840s and 1850s. As David Roberts has shown, paternalistic beliefs were able to cut across religious, political and class divisions in early Victorian England.¹⁹⁴ However, one closely fought distinction was whether paternalism meant the benevolent concern of a local oligarchy, or the benevolence of the state. The impact of increasing state regulation of the care of the insane in Sussex in the mid-nineteenth century illustrates this conflict. Not surprisingly,

since his authority stemmed from an ability to manipulate the close bonds with local land-owners which had so recently been forged, Charles Newington resented as interference the protectionism of central government.

Although the Metropolitan Commissioners in Lunacy who visited Ticehurst in the early 1840s were impressed by standards of care at Ticehurst, they criticised Charles Newington for 'neglect and irregularity' in failing to keep a weekly medical journal which was required by legislation.¹⁹⁵ On their next visit twelve months later in January 1844, Charles Newington claimed that his reason for still failing to comply with the law was that the stationers in London had sent him the wrong book.¹⁹⁶ In September 1844, the commissioners requested that a patient called Mrs White should be discharged because she was sane. Perhaps in an attempt to by-pass the opposition to further state interference they anticipated, this request was made through one of the visitors to Ticehurst, a Kent magistrate called Aretas Akers.¹⁹⁷ However, Newington's response was to try to elicit Akers' goodwill and co-operation in ignoring the commissioners' request by sending him three partridges and a hare from the estate at Ticehurst. Although Akers wrote again enquiring when Mrs White was to be discharged, it was almost another year before she was compulsorily discharged by the commissioners.¹⁹⁹

Diagnosed as suffering from 'moral insanity', her condition in the early case books which Charles Newington was so unwilling to keep was described as 'not improved' up to the date of her discharge.²⁰⁰ However, on her compulsory discharge she was described as 'cured'.²⁰¹ Charles Newington's opposition to state regulation is easily understandable when the difficulty he faced in this case is compared with Mayo's easy persuasion of the magistrates in 'N.B.'s' case.

Charles Newington was far from alone in his opposition to state regulation. The Duke of Richmond, two of whose sons sat in the Commons as M.P.s for Sussex, consistently opposed the building of a county asylum in Sussex, arguing that pauper lunatics were adequately cared for in one of the larger metropolitan private madhouses to which they were sent - and which he took the trouble to visit once a year.²⁰¹ Perhaps pride in the standard of treatment offered at Ticehurst for over fifty years without state regulation, and a genuine sense that such regulation was superfluous, also contributed to Charles Newington's lack of co-operation with the commissioners. In 1850, Sussex was one of the counties to be investigated by the commissioners to discover the reasons why no county asylum had been built since the passing of compulsory legislation in 1845.²⁰² Entrenched local opposition to the rate increases building an asylum would

require can of course account for much of this resistance.²⁰³ Yet at stake too was local versus central control. Foucault's sense of paternalism as uniform, and exceptionally strongly expressed through the institutions of psychiatry, simply does not fit the complex interaction of the growth of institutions for the insane and clashing paternalist ideals in Sussex. In the next chapter, the full impact of state regulation, and the part played by paternalism in shaping developments at Ticehurst will be more fully explored.

NOTES: CHAPTER 2

1. The Regulation of Madhouses Act of 1774 (14 Geo.III, c.49) required provincial madhouses to be visited by local magistrates and a medical practitioner. Dr Mayo's appointment is shown in an 1825 financial return (PP1825(196.)XXI.1-, p.11).
2. ibid.. For Thomas Mayo, see William Munk, The Gold-Headed Cane, (London: Longmans & Co., 1884), pp.220-40; and D.N.B..
3. Official visits by Thomas Mayo were recorded in the Visitors' Reports, 1828-32 (QAL/1/3/E10), and Visitors' Book 1833-45, up to 29 September 1835. Professional consultations were recorded in, for example, Bill Books 1819-26, pp. 4, 15, 67, 123, 132, 133, 139 & 145; 1826-32, pp.21, 30, 51, 52, 55, 57, 60, 62, 73, 79, 81, 83, 94, 111, 141 & 142; 1832-9, pp. 16, 18, 29 & 66.
4. Walter Houghton, The Wellesley Index to Victorian Periodicals 1824-1900, (Toronto: University of Toronto Press, 1972), Vol.II, pp.522-7.
5. William F. Bynum, 'Rationales for Therapy in British Psychiatry, 1780-1835', Medical History, 18 (1974), p.330.
6. Thomas Mayo, Remarks on Insanity; Founded on the Practice of John Mayo, M.D., (London: T. & G. Underwood, 1817), pp. 71-2.
7. William F. Bynum, op.cit. note 5, p.327.
8. Thomas Mayo, op.cit. note 6, p.83; William F. Bynum discusses the implications of moral treatment for the theological doctrine of free will, op.cit. note 5, pp.320-1 & 328-9.
9. Anne Charles Lorry's De Melancholia et Morbis Melancholicus (1765) argued for a distinction between 'melancholie nerveuse', which he believed involved changes in the solid fibres of the body, and 'melancholie humorale'. Lorry also contradicted himself in arguing that melancholy always had a physical cause, and that it could be caused by fear and anguish. (See Dictionary of Scientific Biography). Thomas Mayo, op.cit. note 6, pp.83-4.
10. ibid., pp.80-1.
11. ibid., p.7; Mayo was referring to Thomas Arnold's

Observations on the Nature, Kinds, Causes and Prevention of Insanity, Lunacy or Madness, Vol. I, (London: 1782), and John Haslam's Observations on Madness and Melancholy: Including Practical Remarks on Those Diseases; and an Account of the Morbid Appearances on Dissection, (London: J.Callow, 1809).

12. Thomas Mayo, op.cit. note 6, pp.12-16.
13. For Herbert Mayo (1796-1852) see D.N.B., D.S.B. and Paul F. Cranefield's introduction to the reprint of Herbert Mayo's Anatomical and Physiological Commentaries, (Mechuen, N.J.: Scarecrow Press, 1975). Herbert Mayo argued that:
 ...no change whatever takes place in the functions of the mind, but in conjunction with a corresponding change in some part or the whole of the nervous system... But...mind and matter are logically distinct substances, and...there is nothing in their constant conjunction in our present condition, which renders their separate existence morally impossible, or interferes in the least with any probable evidence to that effect derived from other sources. (ibid., pp.7-8).
14. Mayo criticized Brunonian theory for its 'fatal errors' in op.cit. note 6, p.59. For J.C.Prichard, see Michael R. Neve, 'Natural Philosophy, Medicine and the Culture of Science in Provincial England: the Cases of Bristol 1790-1850, and Bath 1750-1820', (University College London PhD thesis, 1984), pp.279 & 282-3.
15. Thomas Mayo, op.cit. note 6, pp.2-3.
16. Prichard described Pinel as '...one of the best practical authors on the subject of madness'; but:
 Notwithstanding...the testimony of such a writer as M. Pinel, I cannot persuade myself of the accuracy of the reports on which the existence of ["mania without delirium"] rests...
 An emotion without a corresponding impression on the understanding, is like a volition without a motive, or like an effect without a cause.
(A Treatise on Diseases of the Nervous System, (London: T.& G.Underwood, 1822), pp.135-6). Eric T. Carlson and Norman Dain discuss Prichard's eventual

re-appraisal of this view in 'The Meaning of Moral Insanity', Bulletin of the History of Medicine, 36 (1962), pp.130-40.

17. Thomas Mayo, op.cit. note 6, pp.1-2.
18. Michael R. Neve, op.cit. note 14, p.286.
19. ibid., p.281.
20. Thomas Mayo, op.cit. note 6, pp.19 & 26.
21. ibid., pp.64-9.
22. ibid., pp.31-2.
23. Bill Book, 1811-19, p.114. In John Chatfield's case the attempts to restore his physical strength proved ineffective, and he died in the following June (ibid., p.127).
24. See, for example, Bill Books 1811-19, pp.119, 129, 139, 144 & 155; 1819-26, pp.1, 4, 14, 31, 41, 48, 59, 62, 74, 87, 91 & 114; 1826-32, pp.4, 18, 38, 59, 83, 89, 92, 105 & 124; 1932-9, pp.11, 18, 38, 45, 57 & 78.
25. See note 3.
26. Entry for Miss Jeffries, Bill Book 1819-26, p.51.
27. C. Newington, 'An Instrument invented for administering Food and Medicine to Maniacs by the Mouth during a closed state of the Teeth' Lancet 10 (1826), p.845.
28. ibid., pp.845-6. John Haslam referred to the large number of patients who left private asylums with no front teeth after being 'spouted' (op.cit. note 11, p.137, footnote). At the Retreat patients' mouths had been forced open with a key, whilst they were fed with a spoon. In the 1820s, the medical superintendent there, Thomas Allis, introduced a new method of funnelling food into patients' mouths which was copied at other asylums. However, by the 1830s, very resistant patients were fed through a tube to the stomach. (See Anne Digby, Madness, Morality and Medicine. A Study of the York Retreat, 1796-1914, (Cambridge & New York: Cambridge University Press, 1985), pp. 132-3). There is no evidence to suggest that the method described by Charles Newington was ever used anywhere apart from Ticehurst.

29. I am grateful to John Symons for directing my attention to the Wellcome Institute's copy of John Read's An Appeal to the Medical Profession, on the Utility of the Improved Patent Syringe, with Directions for its Several Uses, Shewing, by a Statement of Facts, the Validity of the Rights and Claims of the Patentee, (London: W.Glendinning, 1824), contains commendations from Charles and Samuel Playsted Newington on the usefulness of this hydraulic syringe in removing obstructions. Read, who lived in Horsmonden in Kent, described himself as having invented the syringe after a patient of Samuel Playsted Newington and Robert Willmott died from a bowel obstruction. There is no evidence extant for the claim made by M.A.Lower that Charles Newington helped Read design the original syringe, although Alexander Samuel Newington and Herbert Francis Hayes Newington claimed in 1900 that a letter which was then in their possession, from John Read to Charles Newington, suggested the design had been a joint one (see The Worthies of Sussex: Biographical Sketches of the Most Eminent Inhabitants of the County from the Earliest Period to the Present Times, (Lewes: printed for the subscribers only by G.P.Bacon, 1865), p.255, footnote; and A.S.L.Newington and H.F.H.Newington, 'Some Incidents in the History and Practice of Ticehurst Asylum', Journal of Mental Science, 47 (1901), p.70).

30. Entries for Mr Holloway and Mr Wall, Bill Book 1826-32, pp.44 & 77.

31. John Perceval, A Narrative of the Treatment Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity, (London: Effingham Wilson, 1840), p.240. Thomas Mayo also wrote of patients bearing restraint 'with unexpected patience' (Elements of the Pathology of the Human Mind, (London: J.Murray, 1838), p.97).

32. Quoted in H.F.H.Newington and A.S.L.Newington, op.cit. note 29, p. 65.

33. Following the examples of Robert Gardiner Hill (1811-78) at Lincoln, and John Conolly (1794-1866) at Hanwell, who claimed to have totally abolished the use of mechanical restraint.

34. Visitors' Book 1833-45, entries for 5 October 1842,

10 June 1843, 1 September 1843, 15 June 1844, 25 January 1845, 28 May 1845 and 28 August 1845.

35. John Perceval, op.cit. note 31, p.415. There was no room for seclusion marked on the ground-plans of the asylum, as there was for example at Witney madhouse in Oxfordshire (see William Ll. Parry-Jones, The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries, (London: Routledge & Kegan Paul, 1972, p.136). Anne Digby emphasises that some seclusion included the use of mechanical restraint (op.cit. note 28, p.81).
36. Thomas Mayo, op.cit. note 6, p.59.
37. Mary Morris was admitted on 18 May 1819 (Admission of Patients, 1843-5). The first licence for the Highlands which is still in existence was granted for not more than four patients in April 1830, although a second patient had been admitted one year previously (QAL/1/1/E1).
38. Quoted in Leonard Hodson and Julia Odell, Ticehurst: The Story of a Sussex Parish, (Tunbridge Wells: "Courier" Co., 1925), pp. 153-4. The baby born during the celebrations was Alexander Thurlow Newington, who eventually became secretary of the Asylum (see Newington Family Tree III).
39. On poverty in rural district following the Napoleonic wars see Barbara and J.L.Hammond, The Village Labourer, (London: Longman, 1978), pp.107-11; and G.D.H.Cole and Raymond Postgate, The Common People, 1746-1946 (London: Methuen & Co., 1971 edition), pp.191-2.
40. William Cobbett, Rural Rides in the Counties of Surrey, Kent, Sussex, Hampshire, Wiltshire, Gloucestershire, Herefordshire, Worcestershire, Somersetshire, Oxfordshire, Berkshire, Essex, Suffolk, Norfolk and Hertfordshire with Economical and Political Observations Relative to Matters Applicable to, and Illustrated by, the State of Those Counties Respectively, (London: William Cobbett, 1830), p.158.
41. Census, 1841 (H0107.1109).
42. Quoted in Ticehurst Private Asylum for Insane Persons, (place of publication unknown, c.1828).
43. This patent is still in existence at Ticehurst House. See also M.A.Lower, op.cit. note 29, p.255.

44. Statistical Appendix to the Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor; Containing Tabular Returns from the Several Lunatic Asylums in England and Wales; also from the Principal Lunatic Asylums in Scotland and Ireland (PPI844(621.)XVIII, 1-), p.139.
45. William Ll. Parry-Jones, op.cit. note 29, pp.252-3.
46. David Roberts, Paternalism in Early Victorian England, (London: Croom Helm, 1979), p.125.
47. The County Asylum Act (48 Geo. III, c.96) permitted the erection of county asylums.
48. Bill Books 1819-26, pp.37, 92, & 127; and 1826-32, pp.39, 53 & 71.
49. ibid. 1819-26 pp.46 & 47.
50. M.A.Lower, op.cit. note 29, p.254.
51. Catherine Cobb, George Simons, George Basnet and David and Emily Martineau all reduced their fees; Eliza Wright increased hers (Bill Books 1819-26, p.11; 1826-32, pp. 6, 37, 46, 88 & 108).
52. See Chapter 1, note 96.
53. M.A.Lower, op.cit. note 29, p.254.
54. Leonard Hodson and Julia Odell, op.cit note 38, p.59; Visitors' Reports 19 April & 31 August 1831 (QAL/1/3/E10); Visitors' Book 1833-45, entry for 9 January 1833.
55. M.A.Lower, loc. cit., note 50.
56. John Perceval, op.cit. note 31, pp.90 & 92.
57. On 31 July there were 30 male and 18 female patients resident, suggesting 22 patients shared bed and sitting rooms, 5 had single bedrooms but shared the public sitting rooms, 1 shared a bedroom but had a private sitting room, and 21 had single bed and sitting rooms. Although this would correspond to 22 patients paying two guineas a week or less, 6 paying two and a half guineas a week, and 21 paying three guineas a week or more, the other variations in fees cannot be explained by reference to accommodation (see Table 15).
58. Barbara and J.L.Hammond, op.cit. note 39,

pp.176-200. Alexander Thurlow Newington, who was only eight in November 1831, left an account of the disturbances at Ticehurst:

About 400 of the rioters visited Ticehurst one morning before daylight ...They went...to the back of the Vineyard. Here they were very quiet, saying that they did not wish to disturb 'the old lady', Mrs Newington, who was 90 years of age. Hence they proceeded to the back entrance gates leading to the Highlands, the residence of Mr Charles Newington, and halted. This was about 4a.m.. They sent a deputation to the house to enquire after Mr Newington, saying they hoped he was well and that they would not disturb him. The mob then visited Pashley, where a Threshing Machine was used. This, for safety, had been locked up in the coach-house, and when they appeared determined to destroy it, the late Major Richard Wetherell, who had then recently joined the Militia and was in uniform, armed with a sword and pistol, threw open the doors and threatened to shoot the first man that entered the coach-house. No-one being bold enough to incur the risk, the catastrophe was averted and the machine saved.

(Quoted in Leonard Hodson and Julia Odell, op.cit. note 38, pp.176-7).

59. [John Perceval], Narrative of the Treatment Experienced by a Gentleman During a State of Mental Derangement. Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity (London: Effingham Wilson, 1838), p.219.
60. The accounts list Perceval as resident in Ticehurst House from February - December 1832 (Bill Books 1826-32 p.142; 1832-9, p.36). Gregory Bateson seems to have made an error in suggesting that Perceval was transferred to Ticehurst in May 1832: Perceval's Ticehurst diary began in February 1832. Likewise, Bateson suggested that Perceval probably remained in Ticehurst until the beginning of 1834: however, Perceval's 1840 text referred to him being in

Sevenoaks in 1833. It therefore seems likely that in December 1832, Perceval finally succeeded in persuading his relatives to transfer him to single care, and that the remainder of his confinement was in Sevenoaks. (See Gregory Bateson, Perceval's Narrative. A Patient's Account of His Psychosis, 1830-1832, (New York: William Morrow & Co.Inc., 1974), p.vii; and John Perceval, op.cit. note 31, pp.1-2.)

61. Bill Books as cited in note 60.
62. John Perceval, op.cit. note 31, p.90.
63. M.A.Lower, op.cit. note 29, p.255.
64. John Perceval, op.cit. note 31, pp.91-2.
65. ibid., p.92.
66. ibid., pp.92-3.
67. ibid., pp.92 & 227-8.
68. ibid., pp.93, 97-9 & 146.
69. ibid., pp.93 & 228-30.
70. ibid., p.93; a brewery is shown on the ground-plan of the asylum (see Plate 4).
71. John Perceval, op.cit. note 31, pp.372 & 374.
72. ibid., p.310; and Bill Books 1826-32, p.142.
73. John Perceval, op.cit. note 31, p.416.
74. ibid., pp.241 & 248.
75. Visitors' Reports, 1828-1832 (QAL/1/3/E10) & Visitors' Book 1833-45, entries 9 January 1833 - 16 September 1842.
76. See, for example, Bill Books 1819-26 pp.16, 49, 52, 57, 98, 134 & 147; 1826-32 pp.20, 38, 55, 60, 104, 124 & 130; 1832-9 pp.18, 51, 123 & 143.
77. See, for example, ibid. 1811-19 p.150; 1819-26 pp.16, 21, 59, 70, 71, 94 & 116; 1826-32 p.116.
78. John Perceval, op.cit. note 31, pp.392-404 & 415-6. Henry Charles Blincowe (1796-1861) from Hayes in Middlesex was the son of Robert Willis Blincowe of

Bristol, and educated at University College, Oxford. He was a patient at Ticehurst Asylum from February 1828 until his death in April 1861.

(Alumni Oxon.; Bill Book 1826-32, p.67).

Charles Nunn (d.1836) from London, was a patient at Ticehurst Asylum from September 1824 until his death in January 1836 (ibid. 1819-26, p.133 & 1832-9, p.66).

Alexander Goldsmith (1780-1843), a merchant from Finsbury Square in London, was a patient at Ticehurst from October 1830 - August 1842, when he left the asylum. (ibid. 1826-32, p.146 & 1840-6, p.19).

John Allsopp (1808-43), a surgeon from Linton in Kent, was a patient at Ticehurst from October 1830 until his death in March 1843. (ibid. 1826-32, p.120 & 1840-6, p.90).

79. ibid 1826-32, pp.30, 67, 120 & 146.
80. John Perceval, op.cit. note 31, p.393; Admission of Patients, 1843-5; and Registry of Admissions, 1845-81.
81. See note 79.
82. John Perceval, op.cit. note 31, pp.402-4.
83. ibid., p.404.
84. ibid., p.415.
85. The Select Committee on Funding Exchequer Bills in 1810 found Alexander's uncle Abraham Goldsmid had paid clerks of the Exchequer Bill Office £5,000 stock to gain admission before other brokers. However, since the Goldsmid brothers had broked most of the estimated £330 million exchequer bills not handled by the Bank of England during the Napoleonic campaigns, and some government loans were floated entirely by them, Spencer Perceval's government declined to prosecute, arguing that since on this occasion Abraham Goldsmid had been acting on behalf of other banking houses, he had not stood to profit personally from his malpractice. (See S.R.Cope, 'The Goldsmids and the Development of the London Money Market During the Napoleonic Wars', Economica, 22 (1942), pp.180-206).
86. John Perceval, op.cit. note 59, pp.16-50.
87. S.R.Cope, op.cit. note 85, p.181

88. For David Ricardo, see D.N.B..
89. John Perceval, op.cit. note 31, p.403; & QAL/1/3/E7.
90. John Perceval, loc.cit., note 89.
91. ibid, pp.416-7.
92. The other brother who also signed his certificates was Aaron Asher Goldsmid (1785-1860), QAL/1/3/E7. For Isaac Lyon Goldsmid, see D.N.B..
93. John Perceval, op.cit. note 31, p.158. The original decision to place the melancholic Goldsmid in single confinement may have been influenced by the fact that his two uncles Benjamin and Abraham had both committed suicide (see D.N.B. entry on Abraham Goldsmid).
94. Robert Owen, The Life of Robert Owen. Written by Himself. With Selections from his Writings and Correspondence (London: E.Wilson, 1857-8), p.150.
95. John Perceval, op.cit. note 31, p.251.
96. Admission of Patients, 1843-5.
97. List of the Registered Electors, with the Votes of Such as Actually Polled at the Election for Knights of the Shire, to Represent the Eastern Division of the County of Sussex, in the Third Parliament of His Majesty, King William the Fourth, (Lewes: Baxter, 1833), p.68; and List of the Registered Electors, with the Votes of Such as Actually Polled at the Election for Knights of the Shire, to Represent the Eastern Division of the County of Sussex, in the First Parliament of Her Majesty, Queen Victoria the First, (Lewes: Sussex Press, Baxter and Son, 1837), p.70.
98. Charles Newington, op.cit. note 27, p.846.
99. Lawrence Hodson and Julia Odell, op.cit. note 38, p.58.
100. M.A.Lower, op.cit. note 29, p.255.
101. John Perceval, op.cit. note 31, p.105.
102. See note 99.
103. ibid.; John Perceval, op.cit. note 31, p.317.

104. Stephen Dickenson (1758-1841), a farmer from Pembury, and deacon in the Countess of Huntingdon's chapel in Tunbridge Wells, was in Ticehurst Asylum from March - May 1830, and possibly a second time from March - October 1837 (Bill Books 1826-32, p.105 & 1832-9, p.91). His grand-daughter Susannah Winkworth's Letters and Memorials of Catherine Winkworth, Vol.I, (Clifton: for the author, 1883), pp.3-5 contains an affectionate portrait of him.
105. John Perceval, op.cit. note 31, p.210.
106. H.F.H.Newington and A.S.L.Newington, op.cit. note 29, pp.62-4; and Thomas Walker Horsfield, The History, Antiquities and Topography of the County of Sussex, Vol.I, (Lewes: Sussex Press, 1835), p.578.
107. ibid., pp.588-92.
108. ibid., p.590.
109. By 1835, only four patients are known to have been admitted to the Highlands: Mary Morris, who was described as 'independent' (see footnote 37); Louisa Cay, details of whose social status are not given (who was a patient from April 1829 until her death in April 1845); Lady Charlotte Poole (who was a patient from January 1830 - December 1837); and Frances Prideaux, who was described as 'independent' (and who was a patient from May 1833 until her death in March 1849 after being transferred from the Asylum, where she had been a patient for nine months). (QAL/1/5/E5; Admission of Patients, 1843-5).
110. Of these, William Edgeworth was admitted from Ireland in November 1818 (Bill Books 1811-19, p.155 & 1819-26, p.13); but Mrs Thelwall from Wales, Mrs Creighton from Yorkshire, and Revd Probyn from Boulogne were all admitted in 1834-5 (ibid. 1832-9, pp.50, 64 & 73). In addition, one of the patients at the Highlands, Louisa Cay (see previous note) came from Sunderland (Admission of Patients, 1843-5).
111. See note 104.
112. op.cit. note 44, pp.115-6.
113. Six were listed as 'independent', and one as having 'no occupation'; one was a former 'butler', and three patients former occupations were not given. Five paid four guineas a week or more; three were

- patients at the Highlands; two paid two and a half guineas a week; and one paid only one guinea a week. (Admission of Patients, 1843-5; Bill Books, 1819-26, pp.50, 77, 133 & 139; 1826-32, pp.20, 73, 109 & 113; and 1832-9, p.144).
114. An aunt and nephew, Elizabeth and William Nash, admitted to the Asylum on 25 May and 3 March 1830 respectively; and Louisa Cay and Frances Prideaux (see note 109). (Admission of Patients, 1843-5). Visitors' Book 1833-45, entry for 16 January 1846.
 115. Thomas Mayo, op.cit. note 31, pp.107-16.
 116. ibid. pp.112 & 151-2; and Thomas Mayo, op.cit. note 6, pp.46 & 48.
 117. ibid., pp.31-2; and Thomas Mayo, op.cit. note 31, p.117.
 118. ibid..
 119. Anne Digby, op.cit. note 28, pp.82 & 128.
 120. ibid., p.128.
 121. Thomas Mayo, op.cit. note 31, p.99.
 122. Walter Houghton, op.cit. note 4, p.522.
 123. Thomas Mayo, An Essay on the Relation of the Theory of Morals to Insanity, (London: B.Fellowes, 1834), pp.41-9, especially p.42.
 124. ibid., pp.5-6.
 125. ibid., pp.20, 30, 44 & 46.
 126. Thomas Mayo, An Essay on the Influence of Temperament in Modifying Dyspepsia or Indigestion, (London: B.Fellowes, 1831), p.59.
 127. Thomas Mayo, op.cit. note 123, pp.32 & 43.
 128. It is unclear whether Mayo was familiar with Prichard's earlier discussion of moral insanity in an article on 'Insanity' in J.Forbes et al. (eds) The Cyclopaedia of Practical Medicine, Vol.II, (London: Sherwood, Gilbert & Piper, 1833), pp. 824 & 826-31. A fuller description was given in James Cowles Prichard, A Treatise on Insanity and Other Disorders Affecting the Mind, (London: Sherwood, Gilbert & Piper, 1835), pp.4, 12-26 & 34-71.

129. Thomas Mayo, op.cit. note 123, p.33.
130. ibid., pp.9-10; on the appropriation of the Evangelical initiative by the middle classes, see Catherine Hall, 'The Early Formation of Victorian Domestic Ideology' in Sandra Burman (ed.) Fit Work for Women, (London: Croom Helm, 1979), pp.18-19.
131. Thomas Mayo, op.cit. note 124, p.33.
132. John Perceval, op.cit. note 59, p.275; see also John Perceval, op.cit. note 31, pp.176-7. John Chandos, Boys Together. English Public Schools 1800-64, (London: Hutchinson, 1984), pp.248 & 252; the boys' resistance to Arnold's moral persuasion is described on pp.255-6.
133. Arnold quoted in Lytton Strachey's Eminent Victorians, (London: Chatto & Windus, 1918), p.199; and Thomas Mayo, op.cit. note 123, p.14.
134. ibid., pp. 5, 11-12 & 31.
135. Thomas Mayo, op.cit. note 31, p.132.
136. ibid., pp. 85 & 177.
137. John Perceval, op.cit. note 31, p.387; Thomas Mayo, op.cit. note 31, pp.172-82.
138. Services were performed regularly for the first two years after the chapel opened, but were then only intermittently performed until Autumn 1847 (Visitors' Books, 1833-45 & 1846-69, reports up to 25 October 1847).
139. Thomas Mayo, op.cit. note 31, pp.174-5.
140. ibid., p.99.
141. Samuel Tuke, Description of the Retreat. An Institution near York for Insane Persons of the Society of Friends. Containing an Account of its Origins and Progress, the Modes of Treatment, and a Statement of Cases, (York: W.Alexander, 1813), p.157.
142. Anne Digby, op.cit. note 28, p.101.
143. Thomas Mayo, op.cit. note 31, pp. 99-100 & 152; and Samuel Tuke, op.cit. note 141, pp. 96, 129, 156 & 181.

144. Thomas Mayo, op.cit. note 123, pp.4, 31 & 33-4.
145. Thomas Mayo, op.cit. note 31, pp.99, 175 & 177-8.
146. John Perceval, op.cit. note 31, p.391; see also p.99.
147. Samuel Tuke, op.cit. note 141, pp.150 & 159.
148. ibid., p.149; and Thomas Mayo, op.cit. note 31, p.153.
149. ibid., pp.95 & 100. For an illustration of Mayo's use of 'tempora fandi', see John Perceval, op.cit. note 31, p.375, where Perceval narrates:
 I went on with my complaints again, - the unreasonableness of my treatment [at Ticehurst] in my actual state of health. Dr Mayo suggested that my complaints seemed frivolous; and that my apparent recovery from the state in which he first saw me, together with my terms of gratitude at that time to Mr Newington, seemed to contradict my objections. I had unfortunately stated that Mr Newington's compared to Dr Fox's, was like heaven to hell. About this time I began to feel heated, from physical causes, but chiefly from anxiety of mind. - Dr Mayo continued delicately, I must be allowed to set Mr Perceval against Mr Perceval.
150. ibid., p.176. For similar tactics in the treatment of hysteria in the later nineteenth century see Michael J. Clark, 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry' in Andrew Scull (ed.) Madhouses, Mad-Doctors and Madness. The Social History of Psychiatry in The Victorian Era, (London: Athlone Press, 1981), pp.293-7, especially p.296.
151. Thomas Mayo, op.cit. note 31, pp.96 & 101.
152. ibid., pp.175-6.
153. ibid., p.103.
154. John Perceval, op.cit. note 31, pp.376-80.
155. Thomas Mayo, op.cit. note 31, pp.181-2.

156. John Perceval, op.cit. note 31, p.377.
157. ibid., p.429; and Thomas Mayo, op.cit. note 31, p.172.
158. QAL/1/3/E7; John Perceval, op.cit. note 31, *passim*, especially pp.215, 220, 250 & 382.
159. ibid. p.10; Thomas Mayo, op.cit. note 31, pp.172-3; Mrs Epps, Diary of the Late John Epps, M.D. Edin., Embracing Autobiographical Records; Notes on Passing Events; Homeopathy, General Medicine; Politics and Religion, Etc.., (London & Edinburgh: 1875), pp.195-6. I am grateful to Lawrence Pedersen for drawing my attention to the references to Ticehurst in Epps' diary.
160. The other five patients certified by Alexander Sutherland were Emma Baldwin (admitted 12 October 1831), James Halford (admitted 5 March 1837), John Churchill (admitted 1 July 1840), Revd W.W.Park (admitted 8 October 1842) and Amelia Sims (who was transferred from Sutherland's private asylum, Otto House on 3 May 1843). (QAL/1/4/E5; Admission of Patients 1843-5).
161. R.H.Shryock, The Development of Modern Medicine, (New York: Knopf, 1947), pp.248-72.
162. Thomas Mayo, op.cit. note 31, pp.58-60.
163. ibid., pp.38-9 & 158-60; Herbert Mayo's obituary in the Lancet regretted that:

His papers in the late Medical Gazette on the subject of mesmerism, exceeded all bounds, and many of his friends were fearful, at the time, that his mind had become wrecked. He subsequently embraced hydropathy, and retired to practise this heresy into Germany. Whilst in sound mind Mr Mayo was undoubtedly an able writer and original thinker... He was deficient, however, to a remarkable extent, in worldly wisdom...

(Lancet, ii (1852), p.207). For a discussion of Prichard's views on animal magnetism see Michael R. Neve, op.cit. note 14, p.224.
164. Mrs Epps, op.cit. note 159, p.279.
165. Bill Book 1832-9, p.140.

166. Mrs Epps, op.cit. note 159, p.196.
167. ibid., loc.cit..
168. John Perceval, op.cit. note 31, p.92.
169. op.cit. note 44.
170. William Ll. Parry-Jones, op.cit. note 35, pp.211-2;
Anne Digby, op.cit. note 28, p.231.
171. The median length of stay for those first admissions
between 1 August 1817 and 31 July 1842 and
eventually died in the asylum was 2 - 5 years: that
is, more than even the longest median length of stay
for all first admissions in the same period (see
Table 17).
172. Anne Digby, loc.cit. note 170.
173. ibid., p.8. Nancy Tomes also discusses the
inapplicability of 'social control' theories to
private institutions in the mid-nineteenth century
American context, A Generous Confidence: Thomas
Story Kirkbride and the Art of Asylum-Keeping,
1840-188 . (Cambridge and New York: Cambridge
University Press, 1985), p.xi.
174. Michel Foucault, Madness and Civilisation. A
History of Insanity in the Age of Reason, translated
by Richard Howard, (London: Tavistock Publications,
1967); Andrew Scull, Museums of Madness. The Social
Organization of Insanity in Nineteenth-Century
England (London: Allen Lane, 1979); Klaus Doerner,
Madmen and the Bourgeoisie: A Social History of
Insanity and Psychiatry (Oxford: Blackwell, 1981).
175. On antecedents of the early nineteenth-century
growth in consumer demand see Alan Macfarlane, The
Origins of English Individualism. The Family,
Property and Social Transition (Oxford: Basil
Blackwell, 1978) and J.H.Plumb, The
Commercialisation of Leisure in Eighteenth-Century
England (Reading: University of Reading, 1973). For
the early nineteenth century see Harold Perkin, The
Origins of Modern English Society, 1780-1880
(London: Routledge & Kegan Paul, 1969), pp.91-3 &
96-7.
176. Andrew Scull stresses the increasing importance of
conformity to the community in the wake of
industrialization, op.cit. note 174, pp.71-2.

177. My discussion of late-eighteenth to early-nineteenth century changes in attitudes towards the family is heavily indebted to Catherine Hall's lucid account in op.cit. note 130, pp.15-32.
178. Thomas Mayo, op.cit. note 31, p.99.
179. op.cit. note 44, p.140.
180. Anne Digby, op.cit. note 28, p.94.
181. Catherine Hall, op.cit. note 130, pp.18-19.
182. John Giles Loder, admitted to the Highlands August 1841. Son of Giles Loder (1786-1871). Outcome unknown. (See entry on Giles Loder in Boase; QAL/1/4/E5).
Henry Winkworth, admitted to the Asylum August 1844. Son of Henry Winkworth (d.1869), grandson of Stephen Dickenson and brother of Susanna Winkworth (see note 106). Discharged not improved December 1846. (Admission of Patients 1843-5 and Registry of Admissions 1845-81).
Sir William Walter Yea (1784-1862), admitted to the Asylum November 1825. Educated at Eton and Brasenose College Oxford; succeeded grandfather to baronetcy 1833. Died in Ticehurst. (ibid., and Alumni Oxon.).
Sir Samuel Fludyer (1800-76), admitted to the Asylum and transferred to the Highlands 8 July 1842. Educated at Christ Church Oxford; succeeded to baronetcy 1833. Died in Ticehurst. (ibid., Bill Book 1832-9, p.160 and Admission of Patients 1843-5).
Frances Prideaux, née Patten (d.1849), see footnote 111 & 115. Widow of Charles Prideaux (1760-1833), son of the high sherriff of Cornwall. Died in Ticehurst. (See entry on Charles Prideaux in Boase).
Isabella Keate, née Ramus (d.1859), admitted to the Highlands January 1842. Married to Robert Keate (1777-1857), former president of the Royal College of Surgeons and serjeant-surgeon to Queen Victoria, and brother of John Keate (1773-1852), headmaster of Eton 1809-34. Died in Ticehurst. (See entries on Robert and John Keate in the D.N.B.; and Admission of Patients 1843-5).
Dr George Bragg Blagden (1788-1860), admitted to the Asylum August 1817, brother of Richard Blagden (1789-1861), surgeon-accoucheur to Queen Victoria. Died in Ticehurst. (ibid.; and see entry on Richard Blagden in Boase).

183. Bill Books, 1819-26, p.87 and 1826-32, p.130.
184. Thomas Mayo, op.cit. note 31, p.178.
185. Neither Charles Hayes nor Samuel took an M.D.. Charles went to Trinity College Cambridge, where he graduated B.A. in 1837 (Alumni Cantab.); he became an L.R.C.P., London, in 1836. Samuel went to New Inn Hall Oxford, and graduated B.A. in 1842, and L.R.C.P., London, in 1843 (Medical Directory). Philip Playsted (B.A. Worcester College Oxford, 1842) and Frank (B.A. St John's College Oxford, 1845) both trained for the church, and Philip afterwards became vicar of Combe Keynes, Dorset (1860-73) and Osmington, Dorset (1873-7). (Alumni Oxon.).
186. The Wetherells lived at Pashley Manor (see note 58); for Alexander Beatson see D.N.B..
187. Ticehurst parish church acquired much of its present-day character when it was refurbished in the mid-1850s (Leonard Hodson and Julia Odell, op.cit. note 38, pp.43-4).
188. Annual Address to the Royal College of Physicians, British Medical Journal, i (1871), p.387.
189. Michel Foucault, op.cit. note 174, pp.253 & 276-8.
190. ibid., pp. 252, 260-2 & 265-74.
191. ibid., pp.268-9.
192. For a recent discussion of the idea of contract in psycho-analysis in a historical context, see John Forrester's 'Contracting the Disease of Love: Authority and Freedom in the Origins of Psycho-Analysis', in W.F.Bynum, Roy Porter and Michael Shepherd (eds) The Anatomy of Madness. Essays in the History of Psychiatry. Vol.I, People and Ideas, (London: Tavistock Publications, 1985), pp.255-70.
193. 2g. per week, rather than 3g. (Bill Books 1819-26, 1826-32, 1832-9 and 1840-6).
194. David Roberts, op.cit. note 46, *passim*.
195. Visitors' Book 1833-45, entry for October 1842.
196. ibid., entries for 10 June & 1 September 1843.

197. I am grateful to Nicholas Hervey for drawing my attention to this correspondence. Kent County Record Office, Akers papers (U1157/E1), letter from Aretas Akers to Charles Newington dated 15 September 1844.
198. ibid., letter from Aretas Akers to Charles Newington dated 2 October 1844. The compulsory discharge was noted in Case Book I, p.45.
199. ibid., loc.cit..
200. ibid., loc.cit..
201. David Roberts, op.cit. note 46, pp.106, 118 & 125.
202. Sixth Lunacy Commissioners' Report (PP1851(668.)XXIII.353-), p.9.
203. David Roberts, op.cit. note 46, p.125.

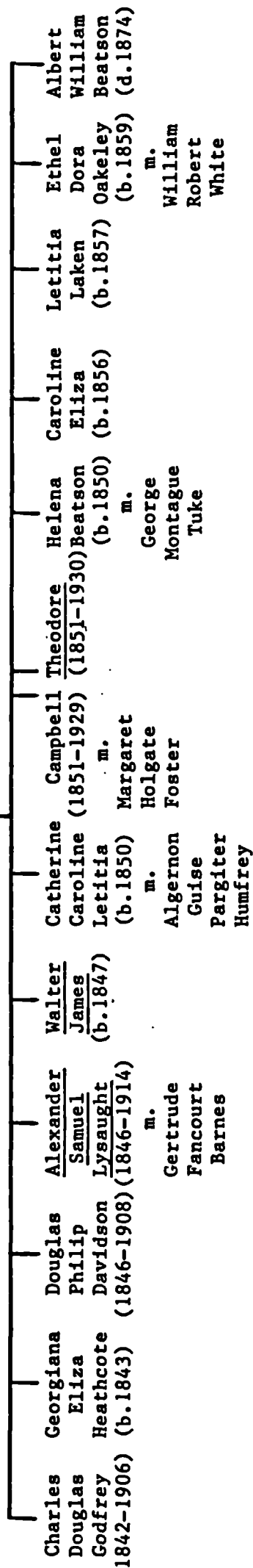
CHAPTER 3: THE MID-VICTORIAN YEARS, 1845-85: CHARLES
HAYES AND SAMUEL NEWINGTON

1) The Newington Family and the Asylum

In the end, the brunt of learning how to comply with the extensive bureaucratic requirements of the 1845 Lunacy Act was borne by Charles Newington's sons.¹ In 1842, Charles Hayes Newington returned to Ticehurst to marry Eleanora Wetherell, and succeeded Robert Hervey as male superintendent of the Asylum.² Two years later, Samuel Newington settled with his young family near his mother-in-law's estate in Frant (see Newington Family Tree IV). The visiting physician who had succeeded Thomas Mayo in 1836, Thomas Thomson (1776-1853), had played a far less active role than Mayo in the treatment of patients at Ticehurst; and his successor in 1846, John Bramston Wilmot (1806-78) followed suit.³ From October 1845, weekly medical journals for the Asylum were kept by Samuel Newington; and the new medical case books were also kept by him.⁴

In 1847, Samuel Newington's own home, Knole House, was licensed for two years as a private asylum. Perhaps partly with the income derived from this source, he was able to build himself a new house, Ridgeway, which itself eventually became incorporated into Ticehurst. The proliferation of houses run by the Newingtons at Frant

Samuel m. Georgiana Oakeley
Newington
 (1814-82)
 Malcolm Beatson
 (1819-98)



NEWINGTON FAMILY TREE IV

and Goudhurst was not without precedent: in the 1820s members of the Finch family had run three private asylums in Wiltshire, as well as two metropolitan asylums.⁵

However, it is a further indication of how successful Ticehurst had become. Apart from the licensed houses, Samuel Wilmot Newington also kept a single patient at Goudhurst; and another of Charles Newington's nephews, Jesse Henry Newington, lodged a single patient in his home at Tenterden in the 1850s.⁶

Although entries were made on some patients in the new medical case books, five years after the new Lunacy Act became law the commissioners found it necessary to:

'...impress upon Mr Newington the absolute necessity of making some record of every patient in the house in the case book.'⁷ The general reluctance of the lunacy commissioners to enforce legal sanctions against private asylum proprietors in the first years of their operation has been described by Nicholas Hervey.⁸ Despite Charles Newington's non-compliance with the new legislation, and resistance to central control, the Evangelical moral values already incorporated into treatment at Ticehurst were shared by Shaftesbury's men on the board. Medically and morally, the commissioners' found much to approve at Ticehurst in the high standards of physical care, the minimal use of mechanical restraint, the range of activities patients were encouraged to participate in,

and the strict segregation of male and female patients, except for some shared meals and social occasions. There is also substantial evidence that some of the commissioners had a great deal of sympathy with higher-class families' desire for privacy and confidentiality, so that although they were determined to foster compliance with the law, they may have looked leniently at Charles Newington's motives. However, one of the commissioners who visited Ticehurst for his first time on this occasion was the non-evangelical Samuel Gaskell (1807-86), who later helped establish a more determined and rigorous style of inspection for the board.⁹ It is unclear whether he actually threatened Charles Newington with prosecution, but entries in the case books on many patients - particularly the very chronic patients who had already been resident in the asylum for over twenty-five years by 31 July 1850 - commenced only in the winter of 1850-1, mostly before the commissioners' next visit in January 1851. Increasingly from December 1850 onwards, entries were made in the case books by Charles Hayes Newington as well as Samuel.¹⁰ In the eighteen months preceding his death, Charles Newington gradually yielded the full control of Ticehurst to his two eldest sons.

As Charles Newington lay dying in April 1852, the Asylum caught fire, and the centre of the main building was

guttled. Although no patients or staff were injured in the fire, only the two wings built by Charles Newington in the early 1830s remained standing: the remainder of the patients' accommodation, and the chapel, had been destroyed. News of the accident was kept from Charles Newington, whose bedroom at the Highlands faced away from the smoke and flames: he died three days later, unaware of what had occurred. Most of the male patients could be accommodated in the wings which remained standing, whilst female patients were temporarily moved to Ridgeway. At the Highlands, beds for five male patients were put in the billiard room. By June, the commissioners were able to report that temporary arrangements were so good that none of the patients had been 'incommoded or disturbed by the change'. Since the asylum had been fully insured, the estimated £10,000 worth of damage was reparable.¹¹

No obituaries of Charles Newington appeared in the medical press, although a notice appeared in the obituary column of the Gentleman's Magazine.¹² On their next visit to Ticehurst, the visitors expressed their regret at his death; but the commissioners allowed it to pass without comment in the report they left at the asylum, only using his death for rhetorical praise of the extent to which Charles Newington had been able to diminish the use of mechanical restraint in their next published report.¹³ As Oxbridge-educated gentleman physicians,

Charles Hayes and Samuel Newington at first emulated their father in emphasising their homogeneity with the local gentry rather than their profession.

However, in view of Parry-Jones' comment that 'One of the failings of the private-madhouse system was that it never achieved any effective corporate organization or identity', it seems important to emphasise that this did not mean that the Newingtons were isolated from other practitioners.¹⁴ On the contrary, evidence from the Ticehurst records suggests that Nicholas Hervey is right to detect the existence of an 'extensive and cohesive network' of asylum proprietors and private practitioners, which provided concerted opposition to any rigorous policing of private practice by the lunacy commissioners.¹⁵ Indeed the existence of such a freemasonry between established private practitioners may provide one explanation of the slowness with which some private asylum proprietors responded to the creation of the more formally constituted Association of Medical Officers of Asylums and Hospitals for the Insane in 1841.

It is unclear whether the Newingtons actually joined the only formal nexus of this group, Alexander Morison's Society for Improving the Condition of the Insane (founded in 1842), which argued the case for unregulated single care, and the need for some use of mechanical

restraint. However, they were undoubtedly on good terms with Morison, and several other members of the society, notably Alexander Sutherland and his son Alexander John Sutherland (1811-67). In 1846, one of the Earl of Carlisle's sons, Revd W.G.Howard, who had been under severe restraint in single care for nearly eight years was transferred by Morison to Ticehurst.¹⁶ Alexander John Sutherland certified nine admissions to Ticehurst between 1849 and 1862, and five others were referred from his two private madhouses, Blacklands House and Otto House. Several other admissions had spent time in some of the private lodgings for single lunatics in Alpha Road near Regents Park to which Sutherland, like Morison, supplied patients whom he then took responsibility for medically attending.¹⁷

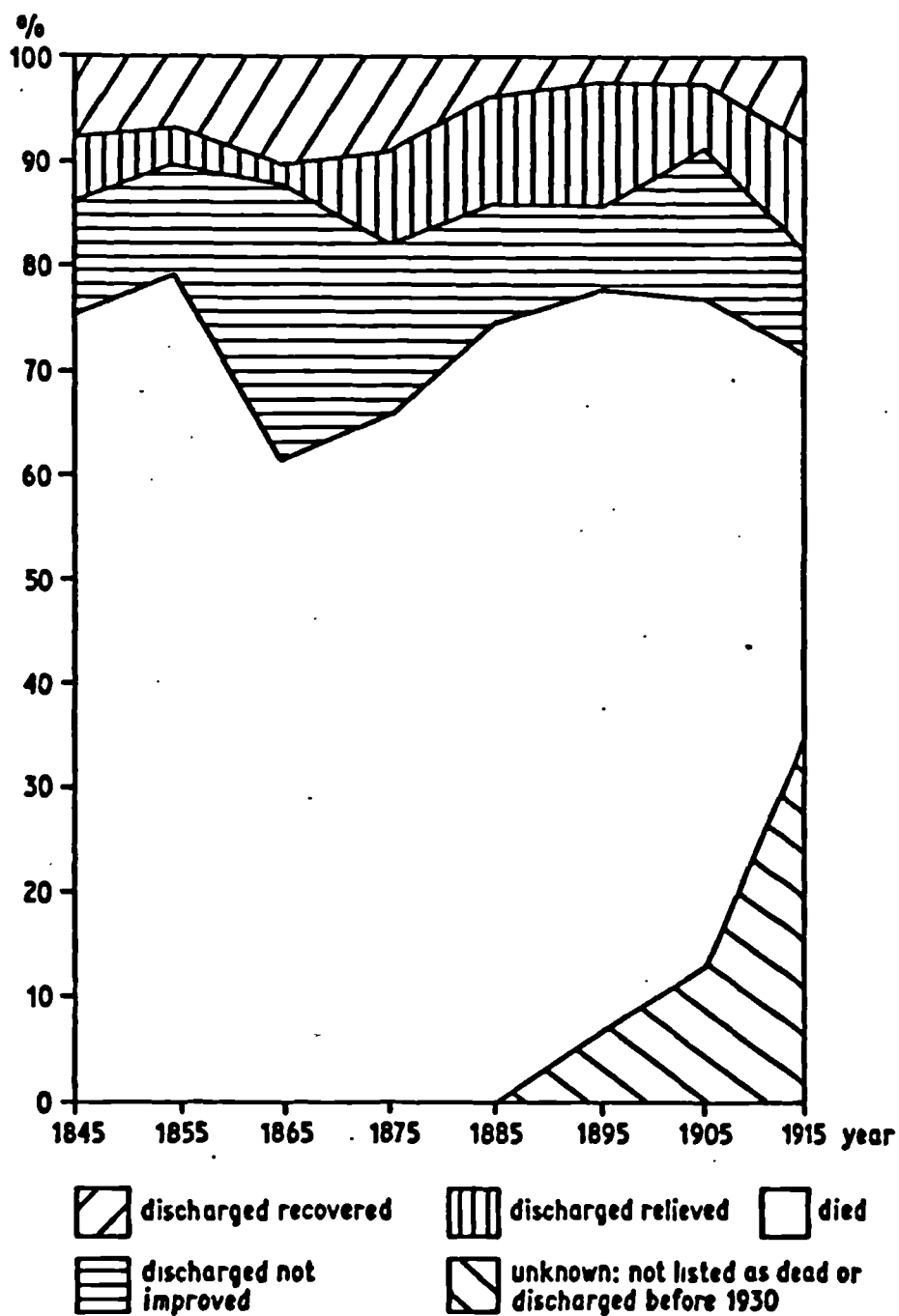
In February 1851, the commissioners criticised Charles Hayes Newington for not notifying them of the transfer of a patient called William Raikes from Alpha Road to Ticehurst in December 1850: somewhat implausibly, he pleaded ignorance of the law.¹⁸ Later certificates which recorded admissions from private lodgings - like those endorsed by the prominent lunacy physician Forbes Winslow in St Leonards - rarely gave a full address of the private lodgings in which patients had been confined.¹⁹ The family feelings which made such discretion sound market policy will be discussed in part four of this

chapter. What it seems important to bring out here is the strength of the consensus between practitioners on how to respond to the lunacy commissioners, and the role of this cartel in securing a supply of patients: members of the Society for Improving the Condition of the Insane continued to send patients to Ticehurst until the early-1880s; and violent or noisy patients whom the Newingtons were unwilling to admit to Ticehurst were referred to Brooke House, Clapton, which was run by Henry Monro (1817-91), whose father Edward Thomas Monro (1794-1856) had also been a member of the Society. Patients were also transferred from Ticehurst to Brooke House and the Priory.²⁰

As Nicholas Hervey has pointed out, the lunacy commissioners' lack of tenacity in enforcing their powers to regulate private practice was partly due to the presence of medical commissioners on the board who had personal or professional links with that private practice. The former Metropolitan Lunacy Commissioners, John Robert Hume (1781-1857) and James Cowles Prichard (1786-1848) were friends of Morison and Alexander Sutherland; and another former Metropolitan Lunacy Commissioner, Henry Herbert Southey (1783-1865), certified three admissions to Ticehurst with the Sutherlands: one with Alexander Sutherland before the board was established, and two after Southey had resigned

Figure 9: Outcome of Stay - Profiles, 1845-1915

Outcome of stay for those resident in Ticehurst
on 31 July of every tenth year, represented as
successively cumulated percentages.

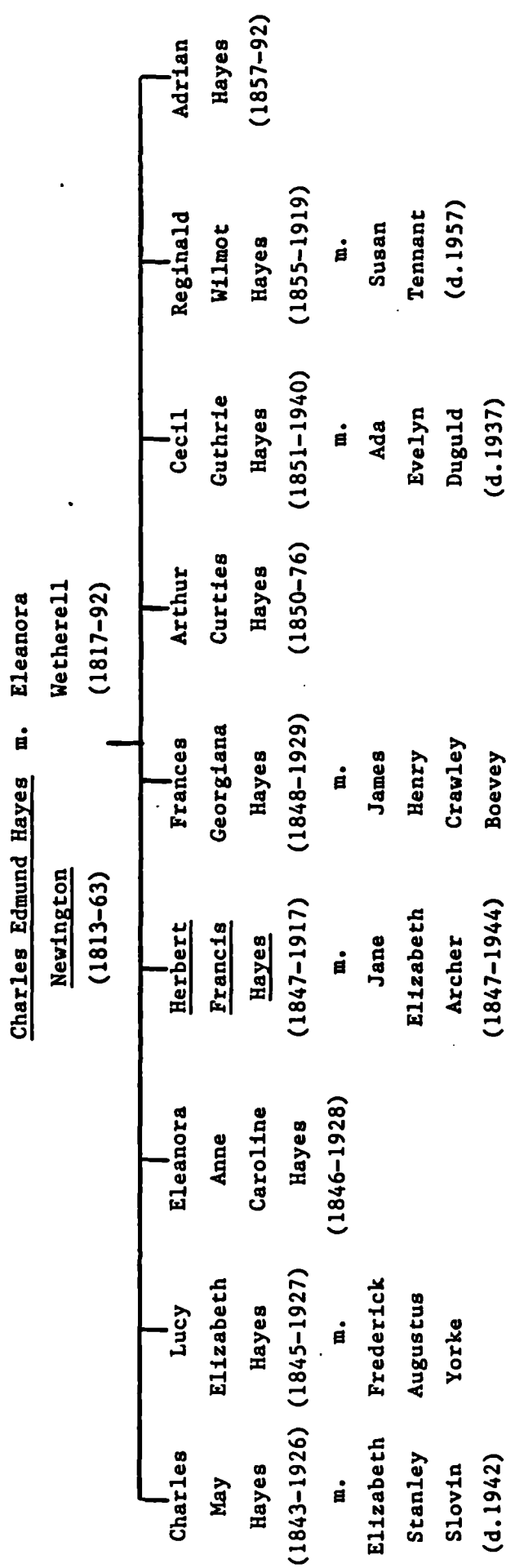


from the board, with Alexander John Sutherland.²¹

Although Samuel Gaskell and James Wilkes (1811-94) were less tractable medical commissioners, from 1857 the Newingtons had an ally on the board in Robert Nairne (1804-87). A contemporary of Charles Hayes Newington at Trinity College Cambridge, on graduating Nairne became physician at St George's, a hospital with strong Evangelical connections, where Charles Hayes had studied for his L.R.C.P..²²

After Charles Newington's death, as well as rebuilding the Asylum Charles Hayes Newington refurbished the Vineyards to accommodate Eleanora, himself and their growing family (see Newington Family Tree V). Both he and Samuel sat on a parish committee which supervised the renovation of Ticehurst church in the mid-1850s, and approved the installation of stained-glass windows in memory of Charles Newington.²³ However, since Charles Hayes Newington died in January 1863, and was survived by his brother for nearly twenty years, as in his father's generation it was the younger brother who made most impact on the asylum, and more is known of Samuel's career.

Like his father-in-law, Samuel Newington was a keen experimental agriculturist and horticulturist. He won a medal at the Great Exhibition in 1851 for an implement he



had designed to sow artificial manure; and an alpine rockery he constructed at Ticehurst was copied at Kew Gardens.²⁴ Throughout the 1850s, Samuel published several pamphlets under the pseudonym 'Sigma' popularizing a planter and other gardening implements which he had invented and patented.²⁵ In 1857, he suggested the reason he remained anonymous was that the demands of his profession left him insufficient time to answer the correspondence which would inevitably result from his name becoming known. Whilst this was no doubt a genuine anxiety, it seems likely that his decision could also have been influenced by concern that Ticehurst's reputation as a discreet private asylum might be compromised by a notoriety which he feared would bring visitors as well as correspondents.²⁶

Just as David Roberts has argued that the Sussex Agricultural Express contained some of the clearest statements of Victorian paternalism as a social and political philosophy, Samuel Newington's agricultural pamphlets were also a vehicle through which he articulated socially conservative and paternalist beliefs. In 1858 he argued that:²⁷

Till all labour be carried on by steam, to teach the poor the elegancies of life is to lift him up above his sphere, and make him discontented with his lot.

However, he also emphasised that the privileges of the upper classes entailed responsibility for the welfare of

the lower classes:²⁸

Although to us the power be given, we should use it mildly; the rich are in a measure responsible for the poor man's happiness; they are not our slaves, - they have hearts and heads as good as ours; we should treat them kindly, if for no other motive but our own interest: for through them it is we obtain the common necessities of life.

Whilst these statements clearly demonstrate the integration of Samuel Newington's values with those of the Sussex gentry, his belief that bonds of personal obligation reinforced social cohesion also affected his response to the central government's lunacy inspectorate. Just as Charles Newington had fostered the continuing goodwill of the magistrates through gifts from the estate at Ticehurst, Samuel Newington sent presents of fruit grown at Ticehurst to Robert Nairne and Robert Lutwidge (1802-73) at the lunacy commission.²⁹

Despite the belief in scientific progress Samuel Newington expressed in his agricultural pamphlets, his interest in therapeutic experimentation was more tentative. Although Alexander John Sutherland became president of the Association of Medical Officers of Asylums and Hospitals for the Insane in 1855, and Sir Alexander Morison and other members of the Society for Improving the Condition of the Insane were early members of the Association, lists of membership before 1862 do not list Charles Hayes or Samuel Newington as members.

They did then join the Association, but did not attend annual meetings, and no notice of Charles Hayes Newington's death appeared in the Journal of Mental Science, although notices did appear in the Lancet and the British Medical Journal.³⁰ Samuel Newington's only medical article, on the sedative properties of mustard baths, was also published in the Lancet (1865) rather than the Journal of Mental Science, although the article was described at some length by the Association journal's editors Charles Lockhart Robertson (1825-97) and Henry Maudsley (1835-1918) in their 'Report on the Progress of Psychological Medicine'.³¹

After Charles Hayes Newington's death, Samuel appointed an assistant physician to help with the care of patients. Arthur Wellesley Edis (1840-93) had taken a course in agriculture and veterinary surgery before studying medicine, so that he and Samuel Newington no doubt had other interests in common apart from medicine; Edis was not a member of the A.M.O.A.H.I.³² However, the interest expressed in his article in the Journal of Mental Science may have led Samuel Newington to attend the July 1865 meeting of the Association, which was held at the Royal College of Physicians. Thomas Bowerman Belgrave, who succeeded Arthur Edis in 1866 as Samuel Newington's assistant physician, read a paper to this meeting on the use of bromides in the treatment of insanity.³³

After Thomas Belgrave left Ticehurst in 1868, three other assistant physicians were appointed. Of the five assistant physicians who were appointed altogether by Samuel Newington, only two had previous experience of asylum work: Belgrave, and Francis Wilton (d.1888) who was appointed in 1871. Although Thomas Belgrave left Ticehurst to take up a post as resident physician at Munster House private asylum in Fulham, none of the other assistant physicians are known to have gone on to other asylums. Arthur Edis' interest in the links between insanity and uterine disorders led him into gynaecology and obstetrics, whilst John Alexander Easton, who was appointed in 1869, went into general practice at Petworth in Sussex. The future career of Wolston F. Dixie, who succeeded Belgrave in 1868, is unclear. Francis Wilton stayed at Ticehurst until he retired to Gloucestershire in 1882.³⁴ As will be discussed in more detail in the third part of this chapter, this lack of specialisation reflected the extent to which the physical treatment of insanity was undifferentiated from general medicine.

Many of the patients whom Charles Hayes and Samuel Newington returned to Ticehurst to doctor would have been familiar figures to them since childhood. As these chronic patients gradually died, the admissions rate increased, although following the devastation caused by the fire, accommodation decreased (see Tables 24 & 25).

After Charles Hayes' death, Eleanora and their nine children moved to Blackheath, and the Vineyards was adapted to accommodate female patients. When Eliza Newington died in 1864, the Highlands was similarly completely given over to patients. From the late 1860s, patients of both sexes began to spend some time in convalescence at St Leonards, in two houses rented by Samuel Newington. In 1872, seven new rooms for male patients were provided; and an extension was built onto the Vineyards for female patients. Another six rooms for male patients were added above a new entertainments hall in 1877; and a detached house for female patients, Quarry Villa, was also opened.³⁵ Between 1 August 1865 and 31 July 1875, the admissions rate was almost twice that of the previous decade (see Table 24). The fourth section of this chapter will discuss how the Newingtons were able to maintain such a high admissions rate. By 31 July 1875, the number of patients resident in the asylum had risen to nearly eighty, a level at which it remained until 1917 (see Table 25).

Underlying this expansion, and of course fuelled by it, was the increasing profitability of Ticehurst. The asylum's annual income for the year in which Charles Hayes Newington died was £14,104 19s. 5 3/4d., but six years later this total had more than doubled, to £30,590 18s. 0 1/4d.. By 1870, the Newingtons' annual profit had

risen to 34.7%.³⁶ Most of these profits were re-invested in the fabric of the asylum; apart from increasing in size, the buildings and grounds were enhanced in other ways. In the 1867-8, gas was supplied to Ticehurst partly because the presence of the asylum made it worth the company's while. Like his father, Samuel Newington was also keen to ornament the asylum's grounds. In 1864, the grass walkways in the grounds were extended. Samuel Newington's horticultural skills were reflected in a comment by the commissioners on 18 June 1864 that the grounds and gardens were in a state which 'could hardly be surpassed'. In the early 1870s an 'Italian garden' was laid out, containing ornamental fountains. By 1877, land owned by the Newingtons around the asylum extended over 200 acres, and the asylum's reliable profits were used to subsidise their less profitable farm.³⁷

Although after Charles Hayes' death Samuel Newington was the only medically-qualified Newington to be involved in the running of Ticehurst, two other members of the family worked full-time at the asylum. Samuel's brother Alexander Thurlow Newington, who had trained as a solicitor, managed the asylum's books and legal work as secretary to the asylum; and one of Charles Newington's cousins Elizabeth, who had worked as Eliza Newington's companion until her death in 1864, was employed as female superintendent in the Asylum (see Newington Family Tree

II).³⁸ In 1875 one of Charles Hayes' sons, Herbert Francis Hayes Newington, who was medically qualified, returned to Ticehurst to assist his uncle; and by 1880 two of Samuel Newington's sons, Alexander Samuel Lysaught and Theodore, both of whom were also medically qualified, moved back to Ticehurst, effectively taking over from Samuel before his death in 1882.³⁹

It is worth noting that, although the Hayes Newingtons remained entitled to a share in the inheritance of the business, they did not profit as fully from the prosperity of the 1860s-1870s as Samuel and his family did. Despite having thirteen children, Samuel and Georgiana Newington were able to send four of their sons, three of whom eventually worked full time at the asylum, to Cambridge in the late 1860s-early 1870s. In contrast, only the youngest of Charles Hayes and Eleanora's seven children went to Cambridge, and he stayed only four terms; Herbert Francis took the cheaper option of studying medicine at University College London and Edinburgh.⁴⁰

In the late 1870s, changes in the national economy led to a rise in consumer prices which increased the asylum's out-goings. Together with the death of several high fee paying patients, this caused Ticehurst's annual profit to fall by 1880 to 18.75%, or £62 16s. per patient.⁴¹

Nevertheless, by the late 1870s Ticehurst enjoyed an unrivalled reputation amongst the medical profession and the lunacy commissioners, which enabled Samuel Newington's sons and nephew to weather the storms of the less hospitable economic climate of the 1880s. In part three of this chapter, the moral and medical treatment offered at Ticehurst to support this reputation will be considered. First, it seems important to look at who was receiving that treatment, and what kind of fees patients and their families were prepared to pay to make the continued expansion of Ticehurst possible.

2) Patients:

The increased documentation required by the 1845 Lunacy Act makes a fuller analysis of the patient population possible. On 31 July 1845, there were 64 patients in Ticehurst - 58 in the Asylum, and 6 at the Highlands. As had consistently been the case since Ticehurst opened, there were more men than women in the Asylum (see Tables 2, 4, 13 & 25). This reflected overall percentages of men and women who were private patients in asylums in England, suggesting that women may have been more likely to be kept in single confinement than men; and that middle-class families were more likely to invest in private asylum treatment for a male bread-winner.⁴² Former occupations are known for all except one of these patients, and three quarters were listed as

'independent', including all female patients except the one whose former occupation was not given. The fifteen male patients who were not living on private capital were all members of the middle class: professionals, merchants or manufacturers, and clerks.⁴³ Fees ranged between about £50 and £500 p.a., with an estimated average of about £150 per year.⁴⁴

Only sixteen of these patients - that is, one quarter - were ever discharged from the asylum. Of these, only five 'recovered'. Four were discharged 'relieved', six were discharged 'not improved', and one was transferred to another asylum. The median length of stay for all patients resident in the asylum at this time was between twenty and thirty-five years (see Figure 9 and Table 33). Almost one third of the patients had already been at Ticehurst twenty years or more by 31 July 1845, meaning that they would have been known to Charles Hayes and Samuel Newington since childhood. The oldest patient, seventy-two year old John Daniel Lucadon, had been a patient for over fifty years, since July 1793. Of the seven patients who had been admitted before 1 August 1817, six were diagnosed as suffering from 'imbecility' or 'imbecility, amentia', and only one as suffering from 'delusions'.⁴⁵ Tombstones to several of these idiots and chronically demented patients, like John Daniel Lucadon, Mary Anne Pugh (admitted in May 1801) and Page Keble

(admitted in September 1812) are amongst the most prominent mid-nineteenth century monuments in Ticehurst parish churchyard. A brother and sister, George and Caroline Simson, who had been admitted in 1820 and 1830 respectively, died long after Charles Hayes, and only shortly before Samuel Newington, having paid the increasingly nominal sum of £50 per year each since 1841.⁴⁶

Nearly half the patients might have dimly remembered a former prime-minister's son who had been a patient for a short time in the early 1830s. Of those patients with whom Perceval had become personally acquainted, only Henry Charles Blincowe remained, and it would be another sixteen years before he died of 'nervous exhaustion consequent on palsy'.⁴⁷ Goldsmid's nephew, Revd Louis de Visme, an Anglican minister, was now a patient in the Asylum; and the Methodist Stephen Dickenson's grandson, a twenty-one year old Manchester silk manufacturer called Henry Winkworth, was the youngest patient in the asylum. Together with the youngest female patient, twenty-two year old Sophia Lindsell, these were three of the patients who eventually left Ticehurst: Louis de Visme was transferred in 1867, after a stay of twenty-seven years, to West Malling Place in Kent; Henry Winkworth was discharged 'not improved' after only two years, and probably returned to live at home; and Sophia Lindsell

recovered and left the Asylum six months after her admission, in November 1845.⁴⁸

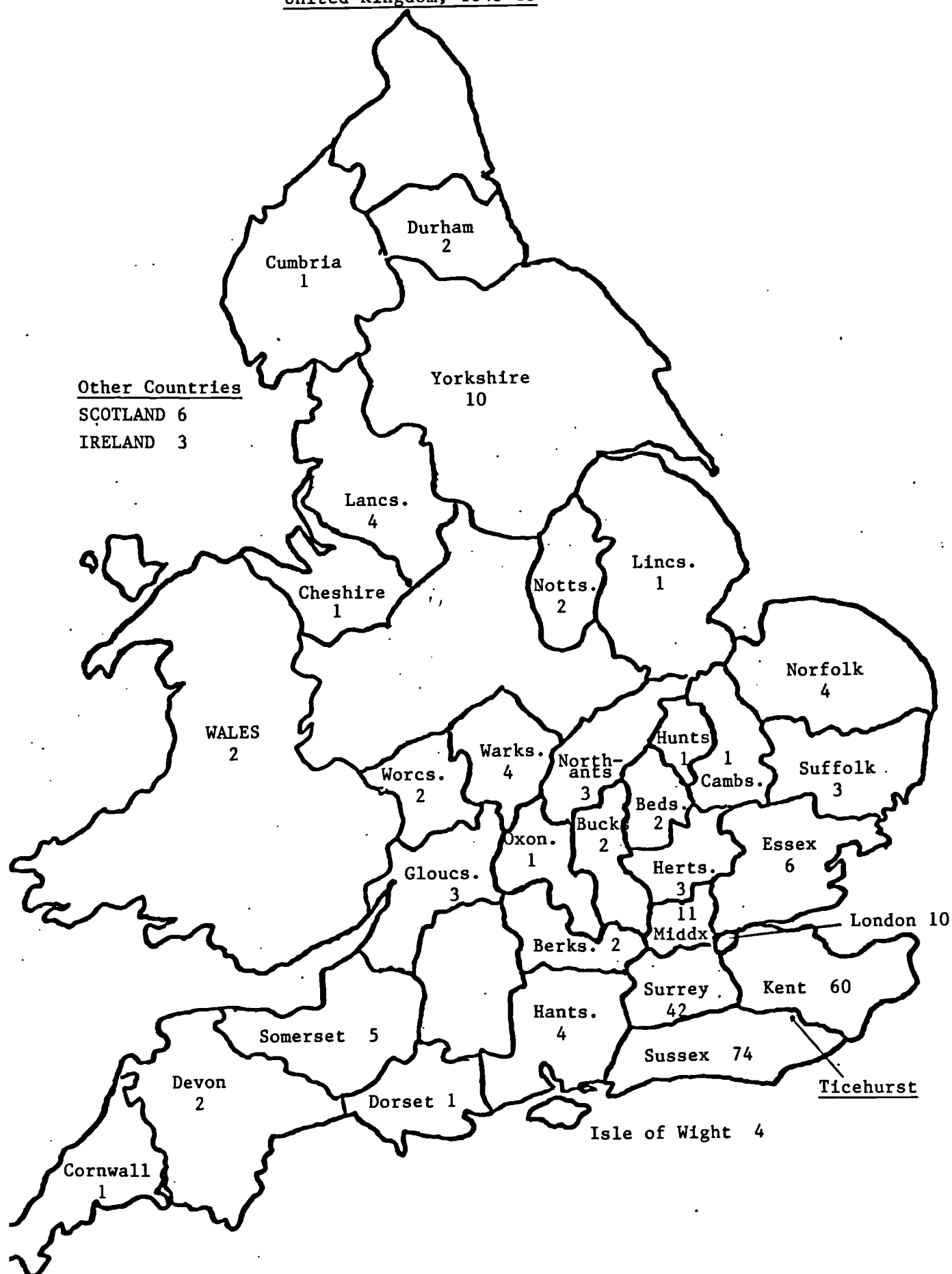
Between 1 August 1845 and 31 July 1885, more men than women continued to be admitted to the asylum, and there were more men than women resident in the asylum at all times (see Tables 24 & 25). Although this reflected national trends in the sex of private patients up to 1890, from 1880 most provincial licensed houses had more female than male patients. Whilst national trends (where women who were pauper lunatics consistently outnumbered men) were consistent with women's greater dependence than men on all areas of poor-law relief, the hypothesis that middle class families were willing to invest more money in private asylum treatment for male bread-winners gains plausibility from the fact that it was as private patients in county and borough asylums (a cheaper alternative than private asylum treatment) that female private patients first began to outnumber male private patients, from 1870. Of greater importance to admission rates at Ticehurst were the number of female patients confined at home or in single care: amongst those cases which were known to the commissioners, women consistently outnumbered men.⁴⁹

Most male and female admissions to Ticehurst were single (see Table 26). Although Ticehurst was comparable to the

Retreat in this respect, only very slightly more male than female admissions were married. However, given the consistently higher class of patients who were admitted to Ticehurst, this need not undermine Anne Digby's hypothesis that married women who might otherwise have become patients at the Retreat were less likely to be separated from their children than men were: indeed, the correlation between an increase in the proportion of married women admitted to the Retreat and a rise in the social status of patients would suggest that her hypothesis is correct, but less applicable to upper-class mothers who had more help in caring for their children.⁵⁰ Admissions to Ticehurst of both sexes were older on average than admissions to the Retreat - 35-44 years old, rather than 25-34 years old: in part four of this chapter it will be argued that this reflected the extent to which asylum treatment was regarded as a last resort by many families who admitted patients to Ticehurst (see Table 27).

The geographical area from which admissions were drawn continued to expand. Occasionally, and increasingly, patients came to Ticehurst from countries outside the United Kingdom (see Table 28). This mirrored not so much a further expansion of the asylum's reputation, as the growth of Britain's interests overseas, and in the number of personnel who managed the Empire. Some patients had

Figure 10: Place of Origin of First Admissions from within the
United Kingdom, 1845-85



worked on plantations, or in the Indian civil service, before being certified and sent to Ticehurst (see Table 29). Others had been travelling abroad in an attempt to shift their disorders, and were confined to an asylum only after this attempted remedy proved unsuccessful.⁵¹

Within England, patients travelled from all over the country to be admitted to Ticehurst (see Table 28.2 and Figure 10). In part, this reflected the increasing ease of travel brought about by the development of the railways, but it was also a product of the Newingtons' growing selectiveness in their choice of patients, and the high-class clientele of the asylum. Despite the Newingtons' charity to a few long-stay, nominal fee paying patients like the Simsons, local families who were eager for their relatives to be treated at Ticehurst were sometimes turned away. Thus in January 1863, a Mr Hudson applied through one of the visiting magistrates, Mr Courthope, for a relative of his to be admitted, but he was refused because the fees he was offering were too low. In August of the same year, a letter of application from a man in Cranbrook 'relative to a lady' was speedily followed by his arrival the same day with his insane sister and two medical men 'but neither the terms nor the patient would suit', and they were sent away.⁵²

Some of those who journeyed furthest within Britain to

become patients at Ticehurst were related to former patients, like Stephen Dickenson's grandson Henry Winkworth, who came from Manchester. Others may have heard of the asylum through friends, as it is possible the essayist William Rathbone Greg (1809-81), whose wife Lucy travelled from Westmoreland to become a patient at Ticehurst in 1857, did from Henry Winkworth's sister Susanna Winkworth (1820-84). A woman who came to Ticehurst from Scarborough in Yorkshire in 1856 was there on the authority of her son, who was a surgeon; and two other admissions from Yorkshire and Scotland respectively were medical men, including the former superintendent of North Riding Asylum, Samuel Hill. This suggests that, although Ticehurst was not advertised in the Medical Directory, its reputation was widespread and high within the medical profession, including those who specialised in the treatment of insanity.⁵³

Another factor influencing a family's willingness to send patients some distance to Ticehurst may have been the desire for confidentiality. A Gloucestershire magistrate Dearman Birchall (1828-97), whose brother-in-law James William Brook (1857-1927) had travelled from Huddersfield to be admitted to Ticehurst in 1866, acted as visitor to Barnwood House Asylum. In 1885 he wrote to his sister-in-law:⁵⁴

I have been at Barnwood this week. Entre nous we have another well known Yorkshire

man, Johnston Scott of Woodhall, Wetherby, brother of Lord Abergavenny's wife. Lord A. ... was my proposer at the Junior Carlton... I am dreadfully sorry to hear that his eldest son, and of course nephew to our patient, is also out of his mind. Is it not sad to have such a skeleton in the closet.

The desire to prevent such gossip may explain why several of the most aristocratic admissions to Ticehurst came from estates at some distance from Sussex: the Earl of Carlisle's son, a daughter of the Earl of Macclesfield, two brothers of the Marquis of Tweeddale, and the Countess of Durham. (Although in the last instance, a highly public and unsuccessful divorce suit by the Duke on the grounds of insanity rendered such discretion futile).⁵⁵

Although the geographical area from which the Newingtons drew their patients expanded, three quarters of all first admissions between 1 August 1845 and 31 July 1885 still came from London or the home counties (see Figure 10). The dramatic increase in admissions from London and Surrey reflected the growth of the metropolis, and of new outer suburbs like Herne Hill, Norwood and Peckham New Town. Many admissions to Ticehurst came from the increasingly prosperous middle class who could afford to build detached villas in quite extensive grounds in these semi-rural suburbs. Eleanora Newington's decision to move to Blackheath when she was widowed was one of many such fashionable choices.

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Plate 6: Samuel Wilmott Newington

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Plate 7: Tattlebury House, Goudhurst

The relatively greater decrease in admissions from Kent than Sussex reflected a different and longer-standing trend (see Table 19 & 28.2). Since the opening of Kent's County Asylum in 1833, West Malling had taken fewer pauper patients, and by 1844 housed 34 private cases.⁵⁶ As well as Samuel Wilmot Newington's house in Goudhurst (see Plates 6 and 7), two other new private asylums in Kent were able to find room in the market. North Grove House in Hawkhurst (which opened in 1843), and Springcroft in Beckenham (opened in 1873).⁵⁷ Offered the alternative, families may have preferred to confine patients nearer home, rather than sending them to Ticehurst, particularly in view of the high fees the Newingtons now charged.

After 1851, when the lunacy commissioners severely criticized West Malling for over-crowding and the extensive use of restraint, the number of patients confined there was reduced to around twenty.⁵⁸ By the late 1850s, Kent County Asylum was desperately over-crowded: in 1859, all admissions from the boroughs of Kent were stopped.⁵⁹ The medical superintendent of Kent, James Huxley, was an outspoken defendant of the usefulness of mechanical restraint in some circumstances. Despite this, in 1857 a patient was able to stab an attendant to death in the asylum.⁶⁰ Staff morale, and the asylum's public image, were both severely damaged.

In the 1860s and 1870s, Kent County Asylum's reputation was poor.⁶¹ A continuing market was created amongst lower middle class families who could not afford treatment at an expensive asylum like Ticehurst, but who would have had to subsidise treatment in the county asylum. Once these private asylums were established, they were also able to aim at a higher-class clientele: thus between 1865 and 1870, North Grove house nearly doubled in size, and an advertisement in the Medical Directory for 1870 noted that, although terms were still described as 'moderate':⁶²

The grounds are extensive, and during the last year a large Bowling-green has been added etc.. The House is well situated - carriages and horses are kept for the especial use of the patients.

At both West Malling and North Grove House, lay proprietors were succeeded by sons who had been able to qualify as physicians. By the early 1880s, North Grove house had been extensively rebuilt, and boasted two detached houses in the grounds for the separate accommodation of upper-class patients. West Malling was able to recover its reputation, and expand to take nearly thirty patients by 1885.⁶³

In Sussex, the only alternative private asylum in 1845 was Ringmer, which took no pauper patients by 1844, but continued to accommodate a few private female cases. In 1854 after allegations of maltreatment the commissioners

ordered that the number of patients at Ringmer should be reduced to three, but the subsequent death of the proprietor, Mrs Ivory, meant that in fact the asylum was closed.⁶⁴ The brand-new county asylum which opened at Haywards Heath in 1859 under the medical superintendence of a keen proponent of non-restraint, Charles Lockhart Robertson was less off-putting than Kent county asylum to lower middle-class families who had to subsidise the cost of treatment. Built to accommodate 450 patients, its design incorporated plans for possible future expansion to a capacity of 800. Whenever possible, Charles Lockhart Robertson recruited attendants who already had experience in other county asylums, rather than the former farm-labourers and army personnel who were employed at Kent county asylum.⁶⁵ Three new small private asylums failed to secure a lasting market: Church Hill House, Brighton (1866-71), Longcroft House, New Shoreham (opened and closed in 1874), and 'Myskyns', Ticehurst (1879-84), run by a retired P.& O. surgeon, who perhaps hoped to benefit from his asylum's location. Only a Roman Catholic asylum run by an order of Augustinian nuns, and a very small private asylum for female patients opened in Winchelsea in 1883, were able to remain open for more than a few years, and neither of these drew off patients who might otherwise have gone to Ticehurst in the way that private asylums in Kent were able to.⁶⁶

Just over 15% of first admissions to Ticehurst between 1 August 1845 and 31 July 1885 were transferred from other asylums, including two patients who were transferred from registered hospitals, and one who was transferred in 1872 from Sussex county asylum.⁶⁷ Only one of these patients came from another private asylum in Sussex or Kent: in September 1854, the lunacy commissioners insisted on the transfer of a patient called Eliza Hawes from Ringmer in Sussex, because they believed she was being kept under excessive restraint.⁶⁸ The private asylums from which most patients were transferred continued to reflect the Newingtons' longest-standing professional affiliations: five patients were transferred from Blacklands House, Chelsea (run by the Sutherlands), five from Brooke House, Clapton (run by the Monros), and eight from the Priory, Roehampton (run by Dr William Wood, a former member of the Society for Improving the Condition of the Insane). Six patients came from one of Forbes Winslow's private asylums, Sussex House in Hammersmith; and six from John Conolly's son-in-law Harrington Tuke's private asylum, Manor House in Chiswick.

Less than half as many patients as were transferred to Ticehurst were discharged from there to other asylums between 1 August 1845 and 31 July 1885. Amongst these too, patients were frequently sent to Brooke House, the Priory or Manor House, although no patients were

transferred to Blacklands House or Sussex House. Two patients left Ticehurst to go to West Malling in Kent. Other houses to which transfers were most frequently made included Camberwell House (run by Dr J.H.Paul), Moorcroft House (run by Dr Stilwell) and Northumberland House (run by Dr J.T.Sabben, but with Harrington Tuke as consulting physician), all in London. Of these, only Moorcroft House also referred patients to Ticehurst. Perhaps surprisingly, only five patients were discharged from Ticehurst to a registered hospital or county asylum: two to Barnwood House in Gloucestershire, two to Northampton Asylum, and one to Bodmin Asylum in Cornwall.⁶⁹ Although it was a registered hospital, Barnwood House took only upper and middle class fee-paying patients. The lower transfer rate from Ticehurst than to it suggests a high degree of satisfaction amongst its clientele; in addition, the negligible proportion of chronic patients who left private care, even if they left Ticehurst, reflected how securely moneyed that clientele was.

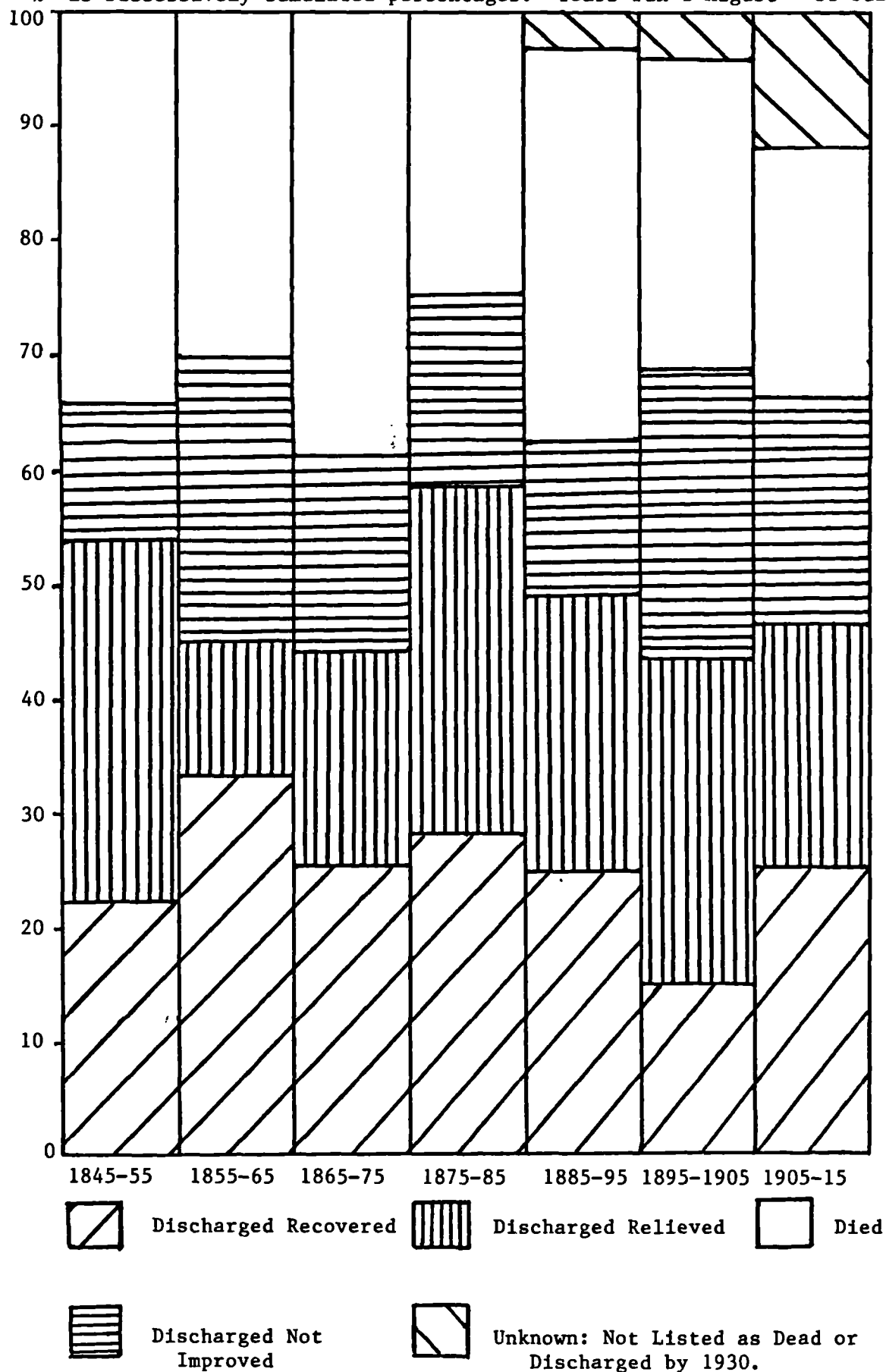
Throughout the period covered by this chapter, fees tripled, from an estimated average of £150 p.a. in 1845, to an estimated average of £450-£500 p.a. by 1875. Within this overall increase, the lowest fees stayed at only £50 p.a., whilst the highest fees rose from £500 to £1,500 p.a. by the early 1880s.⁷⁰ To some extent this mirrored a general increase in retail prices associated

with the growth of consumerism generated by the expansion of the middle class in the 1850s-1870s. After 1875 fees in the middle range plateaued, although the highest fees continued to rise. To place these fees in social perspective, average fees at Ticehurst cost less than half what the Royal Commissions on Oxford and Cambridge in the early-1850s estimated was needed to support a student at one of these universities for a year; and about four times what it cost in 1868 to send a pupil to Rugby School for a year.⁷¹

What proportion of their income were middle and upper class Victorians prepared to spend on health care? Apart from an aside in which he noted that the increasing fashionability of holidays probably helped to reduce doctors' bills, J.A.Bank's otherwise detailed and thorough study of the mid-Victorian middle class makes no estimate of what percentage of their income was disbursed in this way.⁷² A man who wanted to support a dependant at Ticehurst on average fees in the early 1870s, and have left over the £700 Banks estimated as the minimum necessary to maintain a family in the 'paraphernalia of gentility', would have needed to belong amongst the 1,832 people who were taxed under Schedule E in 1871 on an annual income of £1,000-£1,999. Someone wanting to pay Ticehurst's highest fees of around £1,000 in the early 1870s, would have needed to belong amongst the even

Figure 11: Outcome of Stay - First Admissions, 1845-1915

Outcome of stay for first admissions to Ticehurst, represented
% as successively cumulated percentages. Years run 1 August - 31 July.



smaller élite of 356 people who were taxed under the same schedule on an annual income of £2,000-£4,999 in 1871.⁷³

It is hardly surprising that a letters book recording applications for admission between 1857 and 1873 gave the inability to pay fees like this as the most common reason for turning people away.⁷⁴

Looked at from the point of view of first admissions rather than patients resident in the asylum at any one time, 27% of first admissions between 1 August 1845 and 31 July 1885 were discharged 'recovered', and a further 23% were discharged 'relieved'; the median length of stay was only just over one year (see Figure 11 and Table 32). Whilst results like these hardly made Ticehurst a secure investment, families who were dependent on a male breadwinner for a high income may have felt it was worth staking a considerable proportion of their financial resources on the chance of a cure: the not infrequent admissions of merchants, medical men, barristers and financiers would suggest that this was so (see Table 29). The relatively high proportion of admissions who were clergymen reflected not only the upper-class nature of the church as a profession, but also the fact that the church was the only profession where chronic disability did not lead to redundancy: several long-term inmates at Ticehurst, like Revd James Maxwell, Revd Joseph Jefferson and Revd Henry Sullivan remained the incumbents of

prosperous livings.⁷⁵

However, earned income was only one source of finance from which fees at Ticehurst were paid. The most succinct way of defining the social class of patients in Ticehurst - particularly those who were able to stay as long-term patients - is to call them 'capitalist'; not in John Stuart Mill's 1834 use of the term to define the middle classes in opposition to land-owners and labourers, but more (and less) comprehensively, to define all those people who were able to derive a secure middle-class income or more from invested capital, including land-owners.⁷⁶ By 1 January 1875, almost one quarter of patients resident in Ticehurst had been found lunatic by inquisition, and were living on the proportion of their capital set aside for their upkeep by the chancery court.⁷⁷ These patients accounted for most of those paying the highest fees at Ticehurst; and the activity of the courts in laying aside large sums of money for their maintenance, and of the Lord Chancellors' visitors in lunacy, provided some of the momentum for increased fees. Alexander Morison's former patient, Revd W.G.Howard, paid Ticehurst's highest fees of £650 p.a. when he was first admitted in 1846. However, other chancery patients, like Sir Samuel Fludyer, overtook him and were paying £800 p.a. by 1850. It was only after Howard became the eighth Earl of Carlisle in 1864 that

his fees increased, first to £1,000 p.a., and then to £1,500 p.a. by 1880.⁷⁸

The chronically insane who were very wealthy posed a dilemma to those who were responsible for their care in Victorian England. On the one hand, the desire to protect the lunatic's property and the reputation of their families prompted their removal to an asylum or single care. On the other there was a desire to protect the insane from a breach of fortune. Once their property was protected, families might feel guilty that lunatic heirs were not enjoying the privileges of wealth which were seen as rightfully theirs. In 1866, the eighteen year-old heir of a Yorkshire mill-owning family, James William Brook, was admitted to Ticehurst. When he came of age in 1868, a commission of lunacy was held, and a committee appointed to take charge of his affairs. James Brook's brother-in-law, Dearman Birchall, a Leeds cloth merchant whose baby daughter Clara was James Brook's future heir, was one of this committee. Initially paying twelve guineas a week, by 1875 Brook's fees had risen to almost £1,000.⁷⁹

In February 1875, James Brook's aunt went to stay with Dearman Birchall in Gloucestershire. Birchall's diary from this time reflected how sensitive he could be to any suggestion that James Brook was not receiving the best

possible care:⁸⁰

When [Mrs Brook] went home I travelled as far as Cheltenham with her in company of Mr Addison who most strongly urged our taking James William away from Ticehurst, thinking that as he had derived no benefit from Dr Newington's treatment it was time to try some other. I said I had not the slightest opinion that any treatment we might advise would cure him, but that as the cost was about £1,200 per annum I thought he was entitled to greater attention, better apartments and more luxury. I promised to see if [Dr] Needham could recommend any better place.

It seems likely that the medical superintendent of Barnwood House, like the Lord Chancellor's visitor in lunacy James Crichton Browne (1840-1938), who visited James Brook in August 1875, would only have been able to confirm Browne's opinion that:⁸¹

...at Ticehurst [James Brook] commands advantages as regards accommodation, comfort and medical skill unobtainable in any other private asylum in the country.

Nevertheless, in 1877 Brook's fees were actually increased to nearly £1,200 p.a..⁸²

It is difficult to imagine what this money could have been spent on. As William Rathbone Greg wrote in an essay on the increasing cost of living in the Contemporary Review in 1875, 'to live in remote districts or in an isolated fashion' was a way of avoiding expenditure; and, removed from the social and domestic commitments people of their class normally maintained, that was effectively what patients at Ticehurst did.⁸³

By December 1877, Samuel Newington employed 150 servants and attendants, and twelve lady and gentlemen companions, to cater to the needs of sixty-three patients.

Attendants' wages in 1879 were from £34-£100 p.a. for men, and £25-£30 p.a. for women.⁸⁴ Even if James Brook and the Earl of Carlisle enjoyed the exclusive attention of several attendants, their wages can only have accounted for a small part of these patients' bills.

Apart from what Samuel Newington charged for rent and medical attendance, the remainder must have been spent on the best meats, good wine, fine clothes and excursions to Brighton and St Leonards. It is of some significance here that the right to wear patients' cast-off clothing was listed in a lunacy commissioners' report as one of the material benefits enjoyed by attendants at Ticehurst.⁸⁵

Although Dearman Birchall and James Brook's maternal uncle, Edward Armitage, were keen to provide the best for Brook, they balked at the suggestion of the Lord Chancellor's visitors in 1881 that James Brook should 'have a carriage and pair, be taken away from Ticehurst and set up in an establishment in London'. After a meeting with their solicitor in London they agreed:⁸⁶

This recommendation [was]...most reckless and unsuitable. Edward and I [Birchall] each sent an affidavit conveying our objections. The Judges almost immediately said they thought the Visitors had been misled. They granted £250 for the

purchase of carriage and horses and extra £500 for expenses; but insisted on his remaining at Dr Newington's.

By 1881, the blue landau Birchall and Armitage bought for James Brook was only one of many carriages at Ticehurst. Whereas in 1860 only seven or eight patients had carriages of their own, by 1877 these numbers had trebled to a total of twenty-two carriages and thirty-three horses which were kept at Ticehurst, including those kept by Samuel Newington for the patients' exclusive use.⁸⁷

Of the 68 patients who were resident on 31 July 1880, more than half had been resident for less than ten years, and a third for less than five. Only five patients who had been resident on 31 July 1845 were still there, including Caroline Simson. Two patients who were over eighty might still have remembered Perceval; and another two had been admitted before Goldsmid left the asylum in 1842. All five who had been there over thirty-five years had been diagnosed as suffering from 'delusions' rather than 'imbecility' or 'amentia', and one had been admitted on a warrant from the Secretary of State after shooting a policeman. Unusually, equal numbers of men and women were resident in the asylum. The patients former occupations had not changed significantly since 1845: about two-thirds were described as 'gentlemen', 'gentlewomen' or 'independent', but no former occupations were given for eight patients. None of the female

patients whose 'former occupation' was given had been in employment. The male patients who were not independent included five clergymen, five lawyers, a merchant, a banker and a physician.⁸⁸

Just over a quarter of the patients resident on 31 July 1880 were ultimately discharged, but only four were described as 'recovered'. Eleven were discharged 'relieved' and three 'not improved'. Of the forty-seven who eventually died at Ticehurst, twenty-six lived to see in the new century, and twelve to witness the start of World War I.⁸⁹ The patient population in 1880, then, was 'younger' than that in 1845. Although in terms of social class its composition had not changed significantly, the expectations of patients who had grown up in the prosperous 1850s and 1860s were higher. Benefitting from that prosperity himself, Samuel Newington had been able to meet the demands for more accommodation, more attendants, more carriages, and holidays by the sea. What remains to be elaborated is how far, like the original laying-out of the grounds by Charles Newington, these changes also reflected changing ideas of moral treatment; and how changes in medical treatment, despite only slight fluctuations in prognosis, affected the patients' everyday lives.

3) Medical and Moral Treatment:

The early case notes suggest that the treatment Charles Newington offered in the late 1840s continued on the broad principles outlined by Thomas Mayo in his Elements of the Pathology of the Human Mind (1838). Admission books show that Charles Newington followed the kind of simplified system of classification advocated by Pinel, diagnosing most cases as suffering from 'delusions', 'melancholia', 'amentia' or 'imbecility'. The only two exceptions to this were the diagnoses of 'deomania', used to describe three patients who were resident on 31 July 1845, and 'moral insanity'.⁹⁰ Given the prominence of 'moral insanity' as a diagnosis at Ticehurst in the early 1840s, it is surprising that no patients admitted between 1 August 1845 and Charles Newington's death were diagnosed as morally insane.⁹¹ However, taking into account the strength of Charles Newington's resistance to increasing central regulation, his reversion to more traditional diagnoses may have been the metropolitan lunacy commissioners' endorsement of the diagnosis of 'moral insanity' in their 1844 survey of provincial madhouses. Although Charles Newington had been able to categorize patients at Ticehurst within the nosology drawn up by the A.M.O.A.H.I. in 1842, and incorporated in the commissioners' questionnaire in 1844, he chose not to adopt their slightly more complex nosology which included 'monomania', 'moral insanity', 'epilepsy' and 'dementia'

(rather than 'amentia') as well as 'mania' and 'melancholia' in his own diagnoses after 1844.⁹²

'Deomania', or 'theomania', had been coined by Esquirol to describe patients who believed that they were God. It is clear from the admission certificates forwarded by Charles Newington to the magistrates however that Newington's use of the diagnosis was loose, and closer to that of 'demonomania', since he used it to describe patients who believed only that they were possessed by spirits. Although it would be possible to interpret one of these certificates as implying that Charles Newington believed that one female patient diagnosed as suffering from 'delusions' was possessed, and extensive debates on demonic possession in medico-psychological journals in the 1850s mean that this possibility cannot be ruled out, Perceval's account of Charles Newington as eager to interpret old testament accounts of inspiration and possession pathologically make this interpretation implausible.⁹³ From 1850, 'deomania' was abandoned in favour of the more straightforward 'religious delusions'.⁹⁴

Samuel Newington kept the first case notes on behalf of Charles, but his continuous consultation with, and deference to, his father was reflected in his use of the pronoun 'we' when describing decisions and expectations

regarding treatment, a style which neither Samuel nor Charles Hayes adopted in later case notes. The medical framework Charles Newington worked within was humoral: on admission patients were sometimes described as being of a particular temperament; and patients who were too 'hot' were prescribed diaphoretics.⁹⁵ The trend towards more cautious use of depletion, and a supportive regimen, advocated by Mayo in 1838 had continued. No patients at Ticehurst in the late 1840s and early 1850s were bled on account of their mental condition, although one patient suffering from retention of urine and partial paralysis had eleven leeches applied to his left temple.⁹⁶

Patients were routinely purged, with what were generally unspecified 'opening' or 'aperient' medicines: only castor oil, compound rhubarb pills and senna draughts were mentioned by name. It is striking that the most mild of these, castor oil, was even less strong than the colocynth recommended by Mayo in 1838 in preference to aloes and calomel. The strongest purgative named, the senna draught, was prescribed with two 'cathartic pills', emphasising that it was expected to have a more forceful quietening effect than milder laxatives, but clearly differentiating it from drastic purgation. Patients with particularly obstinate constipation were given warm-water and oil enemas, rather than strong purgatives. In his analysis of mid-nineteenth century psychiatric

therapeutics Steven Jacyna has suggested that this shift in the type of purgative prescribed represented a negligible change from eighteenth-century therapeutics, but it seems important to emphasise that it was a change which reflected a central trend in general medicine away from heroic depletion, particularly blood-letting, and towards a more supportive system, which would stimulate the body's natural capacity for health through increased nourishment.⁹⁷

From the early 1850s some patients who had been purged to quell excitement and decongest their systems were afterwards given unspecified doses of the tonic 'Quince disulphate', or quinine, to counteract physical weakness as their mental condition improved, even in cases where mechanical restraint had been employed during their periods of excitement. In cases of strong purgation with compound rhubarb pills, tonics were prescribed simultaneously: thus a patient called Henry Oxenden was given two grains of 'Quince disulphate' three times a day, and purged with compound rhubarb pills every other day; whilst William Raikes, whose constipation was relieved with enemas as well as compound rhubarb pills, was simultaneously given a tonic of iron sulphate with taraxacum, which it may have been hoped would be particularly beneficial because he was liverish. It is worth noting however that the prescription of 'Quince

disulphate' as a tonic occurred only in the earliest notes kept by Charles Hayes Newington, and may represent an innovation by him rather than long-standing practice.⁹⁸ At Ticehurst before the increased prescription of tonics physically feeble patients were given a supportive diet which sometimes included stimulation with alcohol. Thus Captain Mello, who suffered from scrofula, was fed on 'porter, port wine, jellies etc.' in an attempt to restore his bodily health, at the same time as he was given enemas. Patients who were vegetarian were encouraged to include meat in their diet. Mayo had argued that patients of 'sanguine' or 'bilious' temperament could withstand greater depletion than those of 'nervous' or 'serous' temperament, but in the late 1840s the Newingtons suggested of the 'bilious' surgeon Mr Crommelin 'that his mind will recover its tone as his body acquires strength', and they encouraged him to eat meat, which he had not done for two years.⁹⁹

Although Major Cruickshank's insanity was described as the result of an inflammatory fever and congestion of the brain, and medical treatment was said to have been 'to restore the digestive organs, & to remove venous congestion', the only medication prescribed to relieve his regular and intermittent attacks of excitement was (unspecified) 'large doses' of quinine, in this case probably as a febrifuge and anti-periodic rather than a

tonic.¹⁰⁰ The evidence from Ticehurst would suggest that, just as John Harley Warner has argued that the abandonment of blood-letting in clinical practice in Edinburgh occurred before its rejection in medical theory, heroic depletion ceased to be part of psychiatric practice at Ticehurst whilst the medical model of insanity employed by the Newingtons was still one of plethoric congestion. It is clear from the case history of Mr Crommelin above that, like some physicians in Edinburgh, the Newingtons would have explained this by arguing that there had been a change in the robustness of patients' constitutions, rather than in the type of disease. Given the timing of this shift, and the fact that it clearly did not reflect an outright rejection of medical therapy, it makes more sense to see this as part of this general trend in physical medicine, rather than as a response to the critique of heroic methods contained within moral therapy.¹⁰¹

Bodily strength was also fostered through encouraging the patients to take regular exercise. A secondary gain was that physical activity tired the patients, minimising their restlessness. Thus in 1850, Miss Gordon walked about five miles a day 'which we find the best sedative'.¹⁰² Although Mayo had recommended more mild narcotics than opium, the only clear instances of chemical sedation in these years were of a woman patient

who was given (unspecified) 'small doses' of opium to procure sleep, and of a male patient who took half a grain of morphia each night for the same reason. A Miss Davies, who took an unnamed 'composing draught' at night in November 1850, was later prescribed four grains of 'Dover's powders' (a mixture of opium, potassium sulphate and ipecacuanha) before being given six grains of ipecacuanha alone, the nauseant recommended by Mayo in 1838, 'which seems to allay the great irritability'.¹⁰³ Despite more moderate purgation, and the relative absence of chemical sedation, for over four years between March 1846 and May 1850, no mechanical restraint was used. Of the nine patients who were mechanically restrained before or after that, the most commonly given reason was that they were violent; only one patient is known to have been restrained for more general restlessness, 'to keep her from constantly getting out of bed' at night.¹⁰⁴

The fundamental continuity between Mayo's views on insanity and the approach of Charles Newington is nowhere more evident than in the case of a patient called Henry Montague Oxenden. Admitted to the Highlands in May 1849, Oxenden was said to have been 'dull of comprehension' in childhood, but to have become 'as forward as other boys of his age' after being sent to 'a school on the system of Pestalozzi'.¹⁰⁵ Given the social class and age of Henry Oxenden, this was almost certainly the upper-class

school at Cheam run by two distant cousins of Thomas Mayo, Dr Charles Mayo (1792-1846) and Miss Elizabeth Mayo (1793-1865), on the principles of the Swiss educational reformer, Johann Heinrich Pestalozzi (1746-1827).¹⁰⁶

Pestalozzi had been influenced by Rousseau in his belief that education must build on the child's natural experience of the world, teaching through demonstration with objects rather than the immediate elaboration of abstract concepts. For the evangelical Mayos, cultivation of the child's moral sense was as important as intellectual development. Presented with an object such as a leaf or flower, and:¹⁰⁷

Alive to impressions made through their senses, the little ones will by such means be roused to attention, and when the intelligence is awake and stirring the teacher should gradually lead them to the moral lesson or the holy doctrine, connected in Scripture with the object he has shown them.

In the late 1820s and early 1830s this school became so popular that some boys had their names placed on the waiting-list from birth.¹⁰⁸

Transferred at the age of fourteen to Eton, the Newingtons believed Oxenden had suffered 'mentally, morally and physically', leading to his first violent, maniacal attack at the age of sixteen. Despite the advantages of his early education 'The animal development of brain is large and predominates over the moral'. His most recent attack was believed to have been excited by

'stimulating drinks, pandering to the passions etc.'. Apart from 'opening medicine, walking exercise, amusements' and 'attention to diet' however, Oxenden's treatment at Ticehurst included one stratagem which Mayo did not mention in his writings: shower-baths.¹⁰⁹

Since the 1828 ground-plan of the Asylum included baths and shower-baths, it is possible that hydro-therapy had been part of treatment at Ticehurst at least since then, although Perceval made no mention of them, and baths were not included as routinely in the late 1840s as what was described in 1849 as 'the usual treatment, i.e. opening medicine, amusement, air & exercise'; nor even as frequently as 'attention to diet'.¹¹⁰ Given the Newingtons' concern at Oxenden's 'animal' rather than 'moral' development, it seems likely that just as Anne Digby has suggested John Thurnam used cold or tepid shower-baths at the Retreat in the 1840s particularly in cases of 'moral insanity' or on patients with a known history of masturbation, shower-baths were used at Ticehurst in an attempt to subdue patients' 'animal' propensities.¹¹¹ In this period, Oxenden was the only patient on whom shower-baths were used. At least one female patient was given warm baths to promote menstruation, and another female patient was also treated for ammenorrhoea, although it is unclear whether her treatment included baths.¹¹²

The disciplinary use of shower-baths reflected a blurring of the boundaries between medical and moral treatment. Apart from being physically tiring, walks around the varied grounds were expected to stimulate the patient's interest in the external world. Other outdoor activities were also intended to soothe the patient, or absorb their mental attention: fishing, bowls, cricket and hunting with a pack of harriers were amongst the sports and games pursued. Patients who were too physically weak to walk far were taken for carriage-rides, to benefit from the air and varied scenery. Charles Newington's sisters took several female patients on day excursions, and one male patient was sent to the seaside at Hastings 'for a change'.¹¹³ Inside the asylum, reading and playing musical instruments were encouraged, and staff and the Newington family played games like draughts, chess and billiards with the patients. An interest in attending parish services was noted as a sign of improvement in patients, but the Newingtons could be fairly relaxed in their attitude to formal religion, as when they noted that one patient, Revd W.G.Howard, 'much delighted in pretending to perform service from the pulpit in the chapel'.¹¹⁴

Although organized activities were believed to be morally therapeutic, in other respects moral 'therapy' was primarily a question of astute psychological management.

A patient called Henry Borrer was told that he had been confined by the magistrates rather than his father 'it being thought advisable to tell him so, his feelings already being most vindictive towards his father'. In so far as recovery was represented by a return to socially-accepted behavioural norms, shallow imitation was not enough: after Henry Borrer apparently improved, the Newingtons observed that 'when put off his guard his natural disposition breaks out ... it is evident he is on his best behaviour in order that he may be liberated'.¹¹⁵ When another patient called Mr Debary threatened Samuel Newington with violence, Newington '... walked up to him & told him if he attempted anything of the kind I wd. call in a dozen servants, whereupon he quietly walked to his sofa'.¹¹⁶ More persistently violent patients, or those who were eager to escape, were constantly attended by more than one person. Thus William O'Kelly, who had been confined on a warrant from the Secretary of State after shooting a policeman 'often attempts to escape from his attendants, & wd. be violent when restrained in these attempts if he had but one attendant'.¹¹⁷ The numerous staff at Ticehurst helped to reduce the incidence of mechanical restraint.

It was to moral management that the Newingtons attributed their success in handling, if not curing, patients. When Revd W.G.Howard was admitted after being under restraint

for eight years:¹¹⁸

... being a case of such long standing we have not had recourse to much medicine, we have adopted our usual treatment as regards patients reported violent on being first admitted, in this case it has been most successful as Mr H. has now been here one month & has shown no excitement neither has there been the slightest occasion to use any mechanical restraint as he has been uniformly calm & gentlemanly.

Co-operation like this was re-inforced with rewards, so that apart from being allowed to pretend he was preaching from the chapel pulpit, when Howard 'said he had everything he cd. wish for with the exception of a bottle of wine', he was given wine, and seemed 'much pleased at being allowed it'.¹¹⁹

The transition of authority from Charles Newington to his sons was associated with an increased use of mechanical restraint. This increase was not in the number of patients restrained (only nine were restrained in the first five years after Charles Newington's death), but in the frequency with which a similar proportion of patients were restrained, which gradually tailed off after May 1857. Since the trend towards increased mechanical restraint began before the fire (and roughly corresponded to the period during which Charles Hayes and Samuel Newington assumed increased responsibility in the asylum), this cannot be attributed to the difficulties of accomodation after the fire, although some patients were

excited by the event.¹¹⁹

Despite years of practice with Charles Newington, the younger Newingtons appear to have had less confidence than their father in their ability to manage patients through moral persuasion. Like Revd W.G.Howard, when Eliza Hawes was transferred to Ticehurst in 1854 after years of being secluded and restrained at Ringmer Asylum, she was kept free of restraint. Initially weakened by an attack of diarrhoea, as soon as she regained her strength she became violent and self-destructive, biting and scratching her attendants and herself. Although her hands were then restrained, a week later the Newingtons experimented by giving her the free use of one hand. When she again became violent, her hand was placed back in restraint, and she remained almost continually restrained for the next eighteen months.¹²¹

Entries in the case books and medical journals in the early 1850s reflected a new self-consciousness about the use of mechanical restraint. The medical journals particularly stressed the gentleness of the methods of restraint employed, especially when (as was predominantly the case) they were used on female patients. 'Velvet bracelets', a 'velvet belt', and 'soft straps' were among the instruments with which women were restrained.¹²² The emphasis on the soft and tactile fabric from which these

bonds were made clearly differentiated them from the metallic harshness of the chains and manacles with which lunatics had formerly been restrained, underplaying the element of force which was common to both methods. Even Samuel Tuke had advocated fastening straps around patients' ankles to prevent them kicking, and tying patients' elbows to belts around their waists to allow only restricted movement of their arms, but leaving their hands free. Tuke wrote of the arm-straps he used at the Retreat that:¹²³

Some of the female patients ... have the straps made of green moroccan leather, and they will sometimes even view their shackles as ornaments.

The 'velvet bracelets' used at Ticehurst were designed to restrict patients' hand-movements, but the concern to stress that the use of force did nothing to compromise female patients' femininity (and at Ticehurst, gentility) was common to both.

In the early 1850s, male patients at Ticehurst were restrained by 'loose sleeves' which encased the patient's hands as well as arms, and were fastened by straps to the patient's shoulders and upper thighs; or at night their wrists were fastened by 'soft straps' to the sides of the bed. It is worth noting that all of these methods left the patients' legs free, so that those whose arms and hands were restrained during the day were able to continue to take exercise walking in the grounds. More

restrictive means of restraint, such as the straight waistcoat, were occasionally used in cases of extreme violence, as the more continuous use of limited restraint began to decline in the late 1850s; and from 1858 a camisole was used, particularly to restrain patients whilst they were being force-fed.¹²⁴

In case notes from the early 1850s, the Newingtons expressed reluctance at resorting to mechanical restraint. They waited a week before they restrained Henry Oxenden after his re-admission in September 1853, and first tried to reduce his restlessness by removing the attendant from his room at night, despite the fact that Oxenden was violent, tore up his bed-linen and clothes, and continually stripped himself naked. His restraint was ultimately justified by repeatedly appealing to its effectiveness during his previous confinement.¹²⁵ In 1854, the Newingtons somewhat apologetically explained that they had been compelled to restrain a patient called Mrs Thelwall because she was afraid to be alone, several attendants frightened her, but she would physically attack any one attendant who was left with her: yet mechanical restraint had been a routine part of the way in which this long-stay patient had been treated during her periodic attacks of mania since records of restraint began to be kept at Ticehurst. As is clear in both these cases, seclusion in the sense

of leaving the patient alone in their own room, with the shutters closed, in the hope that they would calm down was commonly tried before mechanical restraint was applied; and patients who were noisy or violent to property were sometimes secluded in a room at some distance from the other patients' rooms, where a grille protected the window from being broken. But even after the Asylum had been re-built in 1853 there was no specially-constructed seclusion room or padded cell, and in a reply to the lunacy commissioners' questionnaire on seclusion and restraint Charles Hayes and Samuel Newington suggested that seclusion 'can scarcely be said to have ever been resorted to in this establishment'.¹²⁶

The Newingtons' new self-consciousness at their use of mechanical restraint almost certainly reflected their awareness of possible opposition to the use of restraint from the commissioners and patients' families, rather than their own distaste for the use of force when they believed it was necessary. This sensitivity embraced every situation in which physical force might be used, and not only mechanical restraint. Thus in 1853 they asked Lord Dartmouth's approval for having resorted to force to get his sister Lady Beatrix Legge out of bed.¹²⁷ Although deference to this female patient's aristocratic status made the issue particularly sensitive, even with lower-class patients the Newingtons were reluctant to

over-ride a family's wishes. In 1865, Samuel Newington asked one anorexic female patient's parents to remove their daughter from the asylum after the parents had insisted that no force was to be used in feeding her: the parents' refusal to allow their daughter to be fed with the stomach-pump in this instance actually resulted in the patient being mechanically restrained for the first time, when she was placed in a camisole whilst she was fed with a spoon.¹²⁸

Despite public sensitivity to the use of mechanical restraint, there can be little doubt that the Newingtons not only found it practically useful, but that they believed it to be therapeutic in some cases. Although violence was still the prime reason why patients were mechanically restrained, one apparently new reason which was given for the first time in June 1852 was masturbation. In practice these two reasons overlapped, as when Charles Hayes Newington wrote prior to the decision to restrain Henry Oxenden that:¹²⁹

His irritability & viciousness of temper is no doubt in a great measure to be attributed to his habit of masturbation, and want of proper rest at night.

The two male patients who were most continuously restrained in the early 1850s, Henry Oxenden and Frederick Goulburn, were said to have been mechanically restrained for this reason. No female patients were mechanically restrained until the late 1860s to prevent

masturbation.¹³⁰

Since both Oxenden and Goulburn had experienced periods of mania, one possible interpretation would be that mechanical restraint was used to confine violent and excited patients for pragmatic reasons, but that the Newingtons stressed the patients' masturbation to appease the evangelical commissioners, who would have been more morally outraged by the sinful self-indulgence of masturbation than the use of limited restraint. There is widespread evidence too, not only within the medical profession that masturbation was believed to be physically damaging and to cause insanity, but that within society as a whole the moral and physical dangers of masturbation were believed to be so severe that mechanical and even surgical restraint were sometimes resorted to, so that this reason for mechanical restraint might have been accepted as a valid one by patients' families.¹³¹ When Henry Oxenden's parents visited, his father agreed 'he wished the confinement to be continued', and the Newingtons made a point of noting in the medical journals that 'His [Oxenden's] father requests that mechanical restraint may be placed upon him'. By the early 1860s some patients' relatives were themselves ascribing the patient's insanity to masturbation, when asked of any known cause by the certifying doctors.¹³²

Having grown to maturity in the morally straitened atmosphere of the 1820s and 1830s, Charles Hayes and Samuel Newington shared these popular cultural beliefs. It is clear from the case notes on Henry Oxenden that Charles Hayes saw masturbation as a habit of which, like Mayo, he believed the patient could be 'guilty'.¹³³ Just as Mayo had suggested that parents and educators were responsible for inculcating good or bad habits in their children and pupils, Charles Hayes and Samuel Newington assumed moral responsibility for what they perceived as their patients' wayward propensities. The value of mechanical restraint was not only that it prevented individual instances of physical depletion or damage through masturbation or violence, but that used continuously over a long period of time it broke established patterns of behaviour and created a new habit of abstinence. This belief had foundations in the work of Victorian physiologists like William B. Carpenter and Thomas Laycock, who argued that a habit repeated often enough could become automatic and reflexive.

Although Charles Hayes and Samuel Newington qualified before Carpenter's widely-used physiological textbooks were published, there are two reasons for thinking it likely that his work would have been familiar to them. Firstly, the popularity and success of Carpenter's textbooks, and contemporary assessments that Carpenter

had a greater influence on medical practice than any other Victorian physiologist; and secondly, the fact that in July 1847 Carpenter had published a review of Thomas Mayo's new book, Clinical Facts and Reflections (1847), which also discussed Mayo's 1834 and 1838 publications, including the treatment of 'N.B.' at Ticehurst.

Carpenter's Unitarianism was at odds with the Newingtons' Anglicanism, but as John Seed's sensitive study of liberal culture in Manchester between 1830 and 1850 has shown, by the 1840s unitarians had begun to dissociate themselves from the growing non-conformist campaign for dis-establishment, and were developing a 'growing rapprochement with the established order'.¹³⁴ Like Mayo, Carpenter placed a strong emphasis on the preservation of a concept of free will within a physiological psychology, and on the moral responsibility of the insane. In 1847 Carpenter suggested that criminal actions by the insane resulted from:¹³⁵

... an habitual want of self-control; and that although the individual at the time of committing the crime was so completely under the dominance of passion as scarcely to deserve the name of a responsible agent, he is a proper subject of punishment on account of his previous neglect of self-restraint. (Original emphasis).

In the absence of visible pathological changes, reflex physiology provided a new rationale for the widespread belief that chronic masturbation caused 'spermatorrhoea', or involuntary and 'excessive' seminal discharge; as well

as suggesting that, in long-established and recalcitrant cases like Henry Oxenden's and Eliza Hawes', appeals to the patient's voluntary co-operation through moral therapy would necessarily be ineffective, but mechanical restraint might work.¹³⁶

Carpenter himself stressed that whenever possible the development of self-control was preferable to 'forced restraint', since once aroused a strong emotion was 'a force which must find vent in some mode or other' (original emphasis), possibly in a 'less desirable channel'.¹³⁷ The Newingtons' case notes emphasise the constitutional debility of patients like Goulburn and Oxenden whom they restrained to prevent masturbation, but they did also encourage them to direct their energy into muscular activity during the day.¹³⁸ If Carpenter's application of the doctrine of the correlation of forces to mental and nervous force provided a rationale for this common-sense stratagem, his fuller articulation of that doctrine's chemical-physiological basis in 1857, through an extension of Liebig's theory of the death and oxidation of muscle-tissue in muscular activity to nervous tissue, also provided a rationale for the medical prescription of a supportive diet to nervous patients.¹³⁹

Steven Jacyna has suggested that somatic theories of mind, including reflex physiology, 'had little impact

upon their [alienists'] clinical practice'. Without wanting to dispute his (and Andrew Scull's) argument that a theoretical adherence to a physical pathology of insanity, in the absence of genuine therapeutic resources, supported continuing medical involvement in the treatment of insanity and provided cohesion to the new profession of psychiatry, to see mad-doctors' commitment to somaticism as purely rhetorical is to underestimate the medical, rather than social, seriousness of the historical participants in what evidence from Ticehurst would suggest was a rich and complex dialogue between physiological theory and clinical practice in the treatment of the insane. As was suggested above, the change in the type of drugs recommended as purgatives, which Jacyna sees as a negligible shift, reflected important trends in therapeutic practice in general, as well as psychological, medicine. Jacyna suggests that mid-nineteenth century psychiatric therapeutics were directed at quietening, rather than curing, patients; but within the theoretical framework of reflex physiology suppressing behavioural symptoms, and seeking alternative channels for their expression, could remedy causes.¹⁴⁰

After Henry Oxenden's hands had been confined at night, the slight stains of semen which continued to be found on his sheets were assumed to be the result of involuntary

emissions, 'the effect of constitutional weakness'. The Newingtons very quickly noticed an improvement in Oxenden's bodily health and capacity to take exercise, and within two months of being restrained, he was said by his attendant 'to have "quite given over his nasty habit"' (original emphasis). Despite this improvement, Oxenden continued to be restrained every night for a further three years. After being continually restrained for more than eighteen months, Eliza Hawes had:

... discontinued biting her fingers & tearing her face in consequence of wearing leather gloves she appears to have got rid of the habit...

and she was finally released from routine restraint.¹⁴¹ Used in this way, mechanical restraint could be perceived as part of medical therapy, since the route by which change was believed to be effected was physiological and not simply disciplinarian; and it could be seen as complementary to moral therapy, rather than as antagonistic to it, although it did nothing to enhance the patient's voluntary control.

However, it seems important to emphasise that those patients who were routinely mechanically restrained over long periods of time represented a tiny proportion of cases at Ticehurst. Perhaps because of the unfashionability of mechanical restraint, the practice of using it to prevent masturbation declined. From the early 1860s, the introduction of potassium bromide, with

its anaphrodisiac properties, meant that patients who behaved in a manifestly sexual way were more likely to be chemically than mechanically restrained. (The introduction of bromides will be described more fully below). More moderate restraint - for example by a sheet tucked tightly over the patient in bed - was sometimes used, and combined with close watching by an attendant. In addition, from the early 1870s local applications were made to patients' genitals to discourage masturbation: of alum (a drying agent) in the case of women, and of liquor epispasticus (a blistering agent) in the case of men. The continuing influence of reflex physiology on Samuel Newington's therapeutic strategies was evident in the use of galvanic currents to stimulate stuporous patients from the early 1860s.¹⁴²

Reflex physiology indicated that mechanical restraint could be an effective way of breaking habits, but Carpenter's emphasis on the need for nervous force, once made available, to be expressed could also be used as an argument for non-restraint. Both of these trends were evident in the replies Charles Hayes' and Samuel Newington's professional colleagues made to the lunacy commissioners' questionnaire in 1854. Thus Forbes Winslow said he used mechanical restraint on patients who had 'habits of a destructive character', and found that 'mechanical restraint may for a short period, be applied

not only without detriment, but with positive advantage, as a curative process'; and E.T.Monro suggested in more common-sense language that at Brooke House 'In one case... a more frequent repetition of restraint has broken down the mischievous tendencies'. Whilst A.J.Sutherland praised non-restraint in cases of acute mania because:¹⁴³

Formerly the patient was strapped down to his bed, and ... the horizontal position favoured the congestion of the brain, and added to the development of the already superabundant nerve-force; ... whereas now, by allowing the patient free exercise of his limbs, he works off much of the nervous irritation, and by tiring himself out will sometimes get to sleep even without a sedative.

With the exception of those cases 'of pernicious practices, which no amount of watchfulness can prevent', the Newingtons' own stated preference was for non-restraint, although they stressed their belief that in practice mechanical restraint could never 'be entirely done away with', particularly 'in [public] Asylums which are compelled to admit lunatics indiscriminately'.¹⁴⁴

The treatment the Newingtons recommended to minimise the need for mechanical restraint was moral:¹⁴⁵

A patient, cheerful, and respectful behaviour on the part of an attendant, indulgence towards harmless caprices, but steadiness in not permitting what would prove injurious, change of attendant, where an obvious antipathy has arisen ... will often accomplish what no amount of mechanical restraint will effect.

The emphasis here on the attendant's relationship to the patient is instructive, although it is an aspect of treatment of which it is difficult to form a clear picture, even with the fuller documentation of the case-books. What little is known paralleled in many respects the attitude which Mayo recommended doctors to assume towards the insane: that is one of firmness, and a refusal to be roused to anger. Complaints of mal-treatment and physical abuse of patients were extremely rare, and none were upheld on investigation, suggesting that the Newingtons were able to recruit staff of high quality. Just as Mayo had argued that one reason for confining patients away from home was that confinement within the family could lead to ill-feeling, when patients at Ticehurst were secluded a different attendant was substituted for their regular one 'lest a feeling of dislike should be engendered' in the patient.¹⁴⁶

Wages paid to attendants at Ticehurst compared favourably to average wages for domestic servants. Married attendants were allowed to sleep at home, and male and female attendants could take two weeks holiday a year. Although unmarried attendants generally slept in the room of the patient for whom they were responsible, male attendants were allowed three hours of relaxation every day, and female attendants 'short periods' of relaxation

two times a week, and one full day a month. Job satisfaction, relative to the other employment opportunities available locally, was reflected in a low staff turnover, particularly on the male side, where wages were highest. In 1879, the magistrates commented that one male attendant had been employed at Ticehurst for forty-eight years.¹⁴⁷ Attendants and domestic servants who married each other sometimes both stayed on after they were married to work at the asylum. For unmarried attendants, as much as for chronic patients, Ticehurst could become their home, and the patients their life-companions. One female attendant who worked with a patient called Isabella Surtees from 1871 stayed on as her companion long past retirement age until the patient died at the age of 107 in 1939: a total of sixty-eight years.¹⁴⁸ Despite this sustained proximity however, and the attendants' need at times to assume authority over the patients, the little evidence there is would suggest that these relationships were primarily formal, and that the attendants were expected to defer to their upper-class patients. Thus John Perceval referred to his attendant at Ticehurst as his 'servant', and by the 1880s regulations at the asylum insisted that attendants must 'salute' the patients.¹⁴⁹

In contrast to the day-to-day familiarity of relationships between patients and their attendants, the

Newingtons' relationships with their patients became progressively more distant. Early case-notes from the late 1840s and 1850s suggest that it was not uncommon for Charles Hayes and Samuel Newington to spend hours talking to male patients, and walking in the countryside with them; female patients were sometimes befriended by 'Miss Newington' - probably the doctor Newingtons' cousin Elizabeth, rather than their sister (see Newington Family Tree II & III). The emphasis on 'respectful behaviour' towards patients in the Newingtons' brief outline of moral treatment suggests that, just as Mayo had argued that to neglect moral therapy in favour of physical treatment demeaned human nature, the Newingtons felt that, despite their adherence to a physiological pathology of insanity, courteous attention to patients' feelings was only humane, and perhaps more important, gentlemanly. John Perceval had resented being expected to confide in a jumped-up surgeon like Charles Newington, and advocated greater involvement by the clergy (and other gentlefolk) in the treatment of insanity, not because his own crisis had centred around religion, but because he believed it was more appropriate for 'gentlemen to heal the minds of gentlemen'.¹⁵⁰ As Oxbridge-educated physicians, Charles Hayes and Samuel Newington were better qualified than their father to approach upper-class patients as equals, offering consolation and advice, or simply a listening ear, to

their mentally-distressed patients. Michael Clark has seen the physician's 'moral-pastoral' responsibility for patients as one of the reasons for a rejection of psychological approaches to mental disorder in the later nineteenth century, but what is being suggested here is that whilst the Newingtons viewed their patients' extremes of feeling by the time they were in Ticehurst symptomatically rather than causally, in the 1850s and early 1860s they regarded sympathetic personal attention as one of their pastoral responsibilities as mad-doctors to a high-class clientele.¹⁵¹

Samuel Newington's pragmatic advice to his fellow agricultural employers to treat their labourers with benevolence suggests that an element of pragmatism may also have inspired his kindness towards patients; but his case-notes reflected an imaginative willingness to empathize with his patients' states of mind. Thus in December 1850 when one melancholic patient explained that he felt 'as if his whole body was covered with vultures, with not a place left ungnawed', Samuel Newington commented simply 'he seems to feel acutely not being allowed to be with his family on Xmas day'. The Newingtons' lengthy association with chronic patients also generated feelings of warmth and familiarity between doctor and patient. Charles Hayes Newington's shock and distress at the sudden and unexpected death of a normally

cheerful and vivacious patient called Gideon Simons, who had been in the Asylum since Charles Hayes was eight years old, were evident in the case-notes he wrote up after the patient's death.¹⁵²

However, it would be misleading to over-sentimentalize these attachments: Charles Hayes performed an autopsy on Simons with apparent professional composure. Except in cases of unexpected death, post-mortems were almost never carried out at Ticehurst. But this may have been because of sensitivity to the patient's bereaved family, rather than a lack of motivation on the part of the Newingtons, particularly Charles Hayes. A few weeks before Simons' death, in January 1860, Charles Hayes had asked for permission to do a post-mortem on a patient called John Mayers, who had also been at Ticehurst for thirty years. No relatives were involved in this case, and permission was granted by a friend of the deceased patient. Given the consensus amongst psychiatrists by 1860 that although they believed insanity to be an organic disease it rarely left gross pathological changes which were perceptible to the naked eye, it is unclear why Charles Hayes was keen to perform a post-mortem in this case, even allowing for the unusualness of the opportunity. Although his dissection of John Mayers revealed 'a singular substance hydatidform or cystiform in appearance and structure' in the lateral ventricles of the brain, he does not appear

to have communicated his findings to any of the major medical journals.¹⁵³

The Newingtons' intimacy with their patients was guided by the principles of moral treatment. Thus when a patient called James Coles complained that he was being ill-treated, the Newingtons tried to shift the conversation to another topic, as they would whenever a patient seemed in danger of becoming excited. Visits from the patients' families were also closely regulated to protect the patient from over-excitement: when a visit was considered inadvisable relatives were allowed to watch the patient from a window to see that they were safe, but not to talk to, or be seen by, the patient.¹⁵⁴ Mayo's belief that personal involvement by a family in the treatment of an insane relative could permanently damage good feeling in the family was also mimicked in the Newingtons' policy of changing a patient's attendant whenever the patient was to be secluded. It is in this sense that to emphasise the Newingtons' intentions to create a home-like atmosphere, and informal, family-style relationships could be misleading: their aim was to re-educate patients to participate in a domestically tranquil ambience which the patients' disorders had threatened to destroy, and to do this they needed not only to simulate that ethos, but to make it clear that without co-operation from the patient it could not

continue to exist. At Ticehurst, what Anne Digby has referred to as the 'planned paradox' of an institution which was to be like a home occurred not at the level of physical design, but in the self-conscious structuring of inter-personal relationships to be both socially intimate and emotionally controlled.¹⁵⁵ The Newingtons' own professional distance and sense of the formality of the contract of treatment which Mayo had described was increasingly maintained by a clear separation of the Newingtons' real families from the simulated 'family' of the asylum. The image of the 'family' at Ticehurst lacked the inclusive, religious resonance it had for Quaker patients at the Retreat, but Mayo's belief that the painfulness of exclusion from the family provided a powerful incentive for recovery was incorporated within the asylum in the decreased access patients were allowed to the Newingtons, and an everyday domestic environment, if their condition deteriorated.

Even after Charles Newington's death, patients continued to be transferred from the Highlands to the main building if, like Revd Howard when he smashed several windows, they behaved in a manner which suggested that they had lost their self-control. Since Eliza Newington continued to live at the Highlands until her death in 1864 it seems likely that she may have continued to perform some of the social functions in relation to the patients which her

husband had established. Charles Hayes and Samuel Newington also invited patients to dine with them and to visit their homes. The system of graduated inclusion with, and exclusion from, the Newington family was well illustrated by a letter to the lunacy commissioners concerning a patient called Louisa Manning in 1861 which stated that:¹⁵⁶

On her arrival ... Miss L.M. ... gave way without reason to the most exaggerated paroxysms of passion ... throwing herself into theatrical and indelicate attitudes. On ... our [Charles Hayes Newington] mentioning that if she continued to make such unseemly noises she would be removed from the Highlands House ... Miss L.M. immediately refrained from these exhibitions ... She now enters into the society of our families & attends the service at the Parish Church.

In the early 1860s a teenage epileptic patient called Timothy Brett, whom Samuel Newington described as a 'very affectionate' and 'religious' boy was invited to play with Samuel Newington's children on two consecutive evenings. This patient's subsequent statements that Ticehurst was 'a butcher's house', that he was being interfered with by electricity, and that 'he is God almighty & may do just what he likes' meant that despite Samuel Newington's initial liking for him he was apparently not invited again.¹⁵⁷ Rather than inviting patients into his own home, after Charles Hayes' death Samuel Newington more frequently dined with some of the quiet and convalescent male patients in the common room of the main building.

From 1859, on the advice of the lunacy commissioners, a lady companion was appointed to assist female patients with music, drawing and sewing. This woman, and the assistant medical officers who were appointed after 1864, presided over the dining tables in the main building at which patients were only allowed to sit if they behaved with some self-control.¹⁵⁸ By 1879, five other lady companions, and six gentleman companions, some of whom were medical students, worked at the asylum, and the Newington family seem to have had very little social contact with the patients, except for when they invited well-behaved patients to afternoon tea on Sundays, or attended the asylum's organized entertainments.¹⁵⁹ The appointment of an assistant medical officer meant that even Samuel Newington's medical involvement in the treatment of patients was lessened. The extension of the asylum's buildings, and increased numbers of patients, created a longer medical round. Although the 1860s was a period of some medical experimentation which will be described below, the medical journals and case-books were routinely kept by the assistant medical officer.

Almost no mechanical restraint was used in the very late 1850s and early 1860s, but from the mid-1860s there were once again more frequent instances entered in the medical journals. Frequently, instrumental restraint was said to have been placed on at the patient's own request,

suggesting that Samuel Newington's self-consciousness about the use of mechanical restraint was still strong, and that he impressed this concern on his assistant medical officers. But in June 1869 the commissioners' enquiries about an apparent increase in restraint led them to discover that for 'a long time past' the housekeeper at Ticehurst had been giving female attendants permission to restrain patients mechanically without telling Samuel Newington or the assistant medical officer, and consequently without an entry being made in the medical journals. Three female patients had their feet tied together and to the bed, and a sheet pulled tightly over their chests and fastened to the bed, in addition to wearing camisoles. An entry had been made on this occasion only because on one of his rounds the assistant medical officer who had succeeded Belgrave, Dr Dixie, had found on examining one of the patients feet that they were tied together, and asked if any other patients were similarly restrained. The commissioners reprimanded Dr Dixie for even then making no report of what had occurred to Samuel Newington.¹⁶⁰ Although there is no direct evidence to link the two events, it is worth noting that Dr Dixie left Ticehurst in June 1869, and was the only assistant medical officer who appears to have left not only asylum practice, but also the medical profession after leaving Ticehurst.¹⁶¹

Anne Digby has suggested that at the Retreat the asylum's expansion in size, and the continuity of families who were involved in working there over several generations, led to an institutionalization of its previous familial ambience, and a rigidification of the early, fresh principles of moral treatment into moral management.¹⁶² At Ticehurst, although the expansion in size was less than at the Retreat, and mainly occurred through the addition of new houses each of which formed a small unit, a similar process of routinization can be observed. The rapid turnover of assistant medical officers in the 1860s and 1870s inevitably meant, for long-stay patients at least, a less close and personal relationship with their physician. The return of Herbert Francis Hayes Newington to Ticehurst in the mid-1870s, who had not spent his later teenage years at the asylum, and who had undertaken a university medical education before spending some time working at Morningside Asylum in Edinburgh, confirmed this trend towards a more distant and professional approach, in a manner which will be fully explored in the next chapter.

Central to this shift however before Hayes Newington's return was Samuel Newington's loss of interest in the business which he had inherited, whose high standards needed maintaining but which offered only limited scope for new initiatives. It is hardly surprising that by the

third generation some of the initial enthusiasm and enterprise which had gone into the earlier development of Ticehurst should have flagged. Only one new project in the 1870s was personally cherished by Samuel Newington: the attempt to involve patients in gardening as a form of therapy. The employment of working-class patients in manual labour had been a principle of county asylum treatment since before the programme for compulsory building began in 1845; partly for economic reasons, partly as Doerner has argued because of an extension of the work ethic into the asylum, and partly after 1845 because it was a policy which was actively promoted by the lunacy commissioners.¹⁶³

Because of the high-class nature of patients at Ticehurst, patients were encouraged to engage in sports for physical exercise, and gradually to take up mental occupations as their condition improved, but manual labour was considered demeaning. A patient called Augustus Gawen who expressed enthusiasm for gardening in the mid-1860s was initially discouraged, perhaps with particular vehemence because part of the behaviour which had led to his confinement had been his tendency to consort with working-class people, giving away money and proposing marriage to a fisherwoman. In general Samuel Newington was keen to uphold class distinctions, as when he commented with some distress that a female patient

called Julia Brett who had been paying £350 per annum in her previous place of confinement had nevertheless been allowed to walk out without a bonnet, so that '... her face had become sunburnt ... her appearance being that of a poor person who had been obliged to work in the fields'.¹⁶⁴ But in 1874, apparently after reading of recoveries which had been achieved on the continent through the employment of the insane in gardening, Samuel Newington had three acres of land laid out as allotments for both male and female patients. In practice, only male patients took up the opportunity to garden, under the supervision of a professional gardener who had been specially employed for the purpose. Although the project continued for at least three years, the difficulties of persuading patients to take a consistent interest eventually proved insuperable. A patient who was resident in Ticehurst in 1875 remembered Samuel Newington as a remote figure, who spent more time 'pottering' in his greenhouses than with his patients.¹⁶⁵

The fundamental principles of moral treatment in terms of seeking to combine health-giving physical exercise with mental absorption in the outside world remained the same. Cricket, running with the harriers, and to a lesser extent bowls continued to be prominent activities, to which croquet and archery were added. As was noted in part two of this chapter, increasing numbers of patients

kept their own carriages, and for those who could not afford this luxury the Newingtons kept carriages and donkey-chaises for their patients' use. The renting of two houses at St Leonards meant that convalescent and quiet chronic patients got a chance to be by the sea, to go sea-bathing and for donkey-rides. From Ticehurst, patients were taken to village fetes and flower-shows, and on picnics. As they improved they were allowed to spend days with their families at nearby commercial centres like Tunbridge Wells. Convalescent patients who were still under certificates were allowed out on trial for weeks or months at a time, and in such cases a continuation of the certificates were believed to exert a 'moral control' over the patient, since if they failed to keep their self-control they could be returned to the asylum. Thus in 1870 a formerly alcoholic patient, William Green, was allowed out on trial only on the condition that he did not drink any alcohol; an agreement which in this case the patient managed to keep.¹⁶⁶

Inside the asylum (and sometimes outside in summer), patients were encouraged to spend their time constructively in reading, drawing, painting, sewing (for women), singing and playing musical instruments. Fortnightly concerts were given by a brass band made up of male attendants who had enhanced chances of employment if they could play a musical instrument; and popular

lectures on scientific subjects, such as geology, were given by guest speakers. At St Leonards, patients were allowed to go to the theatre. Increasingly in the second half of the nineteenth century patients were encouraged to play an active part in the entertainments, singing and playing at concerts (on the piano and violin rather than brass instruments), and occasionally preparing talks on subjects which interested them, as Revd Cotton did in May 1867 on bees.¹⁶⁷ This meant that patients were occupied in preparing and rehearsing, as well as attending, these events.

Indoor games like chess, draughts, cribbage and billiards continued to be played between patients, and with their companions. Whist-parties and dances were organized, and convalescent patients were encouraged to hold parties of their own. Mayo had suggested that mentally disturbed patients could derive mental strength from their association with people who were mentally well, and in 1854 the Newingtons argued that:¹⁶⁸

... the example of the more tranquil and docile patients is of great use to those who are intractable, and the association of patients used with discrimination is of essential service.

Although an interest in attending church, and particularly attention to the content of the sermon, were seen as signs of improvement, no strong pressure was placed on patients to be religiously observant. Both

Charles Hayes and Samuel Newington were active in the local parish, but they were far from fanatical about their religion. A patient called Herman Charles Merivale who wrote an autobiography of his experiences in Ticehurst in the 1870s noted that Samuel Newington never attended services in the asylum chapel.¹⁶⁹

Which aspects of patients' behaviour did the Newingtons feel it was particularly important to regulate, and which were they prepared to rank as 'harmless caprices'? Their concern to prevent patients masturbating has already been documented. Other overtly sexual behaviour - like the propositions of a male patient called Revd Patterson to his male attendant - also led to a firm and pragmatic response; in this case to the patient being bolted in his room at night while the attendant slept outside. The Newingtons' case-notes revealed a general concern with sexual propriety, referring even in this medical context to semen as 's___n', and taking care to avoid any possible sexual innuendo, as when Charles Hayes Newington described a female patient who had 'exposed herself to [crossed out] not taken proper precautions against damp ground'.¹⁷⁰ However since it was not uncommon for patients to remove their clothes in public the scope for a possible misunderstanding here was real, and could have had a material effect on what happened to the patient in the future. Patients' ability to conduct themselves with

sexual decorum was one of the Newingtons' central concerns when considering a trial away from the asylum, or discharge.

Swearing and obscene language were also disapproved of. This partly reflected a strong sense of the kind of behaviour which was appropriate to a patient's social place. Thus Charles Hayes Newington described one female patient's language as so 'outrageous and coarse ... that, as a lady, it was surprising where she could have heard it'; whilst Revd Patterson cursed in 'language such as no clergyman in his senses wd. have used at any time, much less so on Sunday'.¹⁷¹ However such behaviour by itself did not prevent patients from attending communal meals, entertainments, or chapel services, although obscene language or behaviour was one reason for patients not being permitted to leave the grounds of the asylum in their walks, or attend the parish church. This demonstrated clearly the strength of the Newingtons' conviction that more disturbed patients could benefit from association with convalescent or quiet patients, rather than a belief that better-behaved patients' condition might deteriorate if they associated with patients who were noisy and disruptive.

When Revd Patterson attended morning prayers in the asylum chapel:¹⁷²

he stops his ears with his fingers & fidgets about, and on one occasion he gave me a dig in the ribs & told me to "hold my row" while I [Thomas Belgrave] was reading the prayer!

But as the exclamation mark here suggested, such interruptions were treated with good humour. It was with similar tolerance that Samuel Newington had remarked in 1860 that when Revd George Kenrick attended chapel 'his loud & extraordinary singing attracted the attention of the rest of the congregation'. (Incidentally, Kenrick was a former minister of the Rosslyn Hill Unitarian Church in Hampstead, of which W.B.Carpenter was organist for over seventeen years).¹⁷³ Only one patient, called Letitia Walker, was asked to leave because she was persistently antagonistic to other patients; and a male patient called Charles Mawley was said to have been removed because he was 'much disliked by other patients', but only after he had also encouraged another patient to leave the grounds of the asylum with him.¹⁷⁴

Some physical rough-and-tumble was tolerated, so long as it did not become too violent or malicious in intent. Thus in April 1860 Revd Louis de Visme was described as 'very fond of striking when in close quarters', and over two years later as 'not dangerous, though he often hits very hard in his play'; but five years later after he broke a wooden poker over Thomas Belgrave's shoulder and threw a chair at him, de Visme's relatives were asked to

remove him.¹⁷⁵ Violence which was seen primarily as an attempt to provoke the attendants and doctors was sometimes thought best ignored, as when a patient called Mrs Welstead:

used every expedient to excite & rouse me [Thomas Belgrave]. She abused, taunted & swore, then tossed a plate at my head, also a book & finally hit me a blow on the nose!

but this behaviour did not lead to the patient being restrained, or any other special treatment.¹⁷⁶

With many patients, a visible reminder that they were outnumbered by attendants was sufficient to inhibit violence. Thus in 1855, when a patient called Mary Turney threatened violence, she:¹⁷⁷

immediately exercised self-control upon the appearance of three attendants in her room & she remarked "I shd. like to knock that candlestick out of yr. hand but I see it is no use trying it here, where I have been before I have always screamed & been able to get my own way. I can't do that here so I shall be quiet..."

Apart from the low staff:patient ratio, generally low levels of mechanical restraint for violence were maintained by a policy of refusing admission to very violent or suicidal patients, and transferring patients who were persistently violent after admission. In 1869 the commissioners recommended that Samuel Newington should issue guidelines to his staff of the only circumstances in which mechanical restraint ought to be employed, to prohibit 'excessive' restraint like that

which had recently been discovered, which Newington did; but his own preferred solution in the long term was to limit the number of acute admissions so that the incidence of violence was kept as low as possible.¹⁷⁸

Great care was taken to keep faecal smearers, and those who were so depressed that they completely neglected themselves physically, as clean as possible. No doubt this was partly informed by the practical consideration that dirt, and especially fetid air or 'miasma', was believed to cause disease. One of the disadvantages of the Asylum being built on the design of a house rather than a hospital was that ventilation was less good: in October 1856 the commissioners asked the Newingtons to improve the ventilation in a sitting-room which was occupied by 'a gentleman of dirty habits'.¹⁷⁹ Almost two years later, a partially paralysed woman called Anne Farquhar was admitted to Ticehurst after having been in bed for three years at home. Although this woman was said to have been attended by 'most of the eminent medical men in England' (her certificates were signed by John Conolly), she had refused to be washed or to allow her bed-linen to be changed, and on admission her hands and arms were 'begrimed with dried faeces' and she was covered in boils. One of the attendants who went to collect her from home complained a few days later that 'she has not been well since she entered Mrs Farquhar's

room at Blackheath, the atmosphere of it was so foul and the stench so great.'¹⁸⁰ It is worth noting that 1858 was the first summer of the 'Great Stink', when widespread publicity was given in the press to fears that the smell from the highly-polluted Thames was a threat to Londoners' health.

However, within three days of Mrs Farquhar's admission to Ticehurst, where she was washed, the windows of her room were kept open, and she was encouraged to sit up and read, she declared 'that there is nothing so delightful as a good wash & plenty of fresh air'. This transformation was represented by Charles Hayes Newington not only as one which was beneficial to Mrs Farquhar's physical health, but as a moral one, from a state of polluted and idle animality to one of virtuous and busy humanity. At first Mrs Farquhar had eaten '... more like an animal than a human being ... chews her animal food & then spits it out' and she was 'without ... any rational employment'; but a week later she took 'her dinner at the table in a cleanly manner ... reads religious books & the newspapers' and was 'very amiable & grateful'.¹⁸¹

However, it was primarily dirt which was believed to carry the threat of disease which was seen as morally unwholesome, and some messiness and damage to property were tolerated, although a preference for tidiness and care with appearance were always seen as signs of

improvement in a patient's condition. Before he was transferred, Charles Mawley was allowed to spend hours mixing grease and cigar-ash, to make what he described as 'hair-dye'; and in May 1865 the commissioners criticized Samuel Newington for allowing a patient called Mr George Wood to draw all over the floor of his sitting-room with white chalk. Another patient called Fritz Steiner sketched a 'landscape' on the walls of his room, which he hoped would be removed and hung at the Royal Academy. In this case the doctors' initial tolerance somewhat back-fired, since three weeks later when Steiner's room was re-decorated he created a disturbance when he next saw the assistant medical officer, Francis Wilton, and shouted 'Where is my drawing, you bugger'.¹⁸²

Within the boundaries set by the desire for cleanliness, physical safety and sexual restraint, considerable freedoms were allowed to patients. Apart from being able to keep their own horses and carriages, they were permitted to have pets with them in the asylum, like the former editor of the Provincial Medical and Surgical Journal, William Harcourt Ranking (1814-67), who kept a dog at Ticehurst in the 1860s.¹⁸³ Their freedom of physical movement may be gauged by the fact that, despite close attendance, in the middle decades of the nineteenth century two patients managed to escape. In 1857 a patient called Thomas Wright was able to give his

attendant the slip, and walked all the way to London without being apprehended. He was only re-captured when, pretending to be unable to talk as he often did, he handed the guard at London Bridge railway station a note saying 'I belong to the Ticehurst Asylum & want to go there but have no money'.¹⁸⁴ More tragically, in 1861 a patient who had been admitted after he had amputated his penis, and who suffered from increasing depression as his rationality returned, was able to walk off the grounds of the asylum and drown himself in a local pond.¹⁸⁵

Although in 1854 the Newingtons had emphasised the importance of 'steadiness' or consistency in responding to patients' behaviour, there was naturally some variation in the way that people at Ticehurst handled the patients. It is impossible to tell how large the gap may have been between the doctors' and the attendants' moral values, but it seems likely that the Newingtons' preoccupation with propriety and respectability would have been a less central concern for their lower-class attendants. On the other hand, having to deal with patients face-to-face may have made the attendants more intolerant of threats of violence, as their seizing of the initiative over the use of restraint in the late 1860s would suggest. Of the doctors, Charles Hayes Newington's case-notes most clearly show the continuing influence of Evangelicalism, in his moral seriousness and

capacity to be shocked; whilst Thomas Belgrave's notes were exceptionally light-hearted - he exclaimed more with amusement than outrage.

In his now classic study of Victorian moral attitudes Walter Houghton has argued that 'moral enthusiasm', or the belief that there were natural springs of goodness in human nature, frequently co-existed with an attitude of 'moral earnestness' and emphasis on the need for discipline and self-control.¹⁸⁶ Certainly Carpenter had suggested in his review of Mayo's writings that free will consisted in a choice between noble and ignoble feelings, which could be conditioned by habit; that it was not simply a question of reason triumphing over passion, but rather a question of restraining selfish emotions and giving rein to generous and industrious motives. His sense that there was a conflict in human nature between dispositions was similar to Mayo's, but Carpenter believed that those whom Mayo had perceived as 'brutal' or lacking in innate moral sense lacked feelings ('a desire of the world's approbation, or an affection for his family') rather than will (original emphasis).¹⁸⁷ Although Charles Hayes and Samuel Newington described their patients' disorders as a triumph of animality and emphasised their lack of self-control, they also described them as perverted, and lacking in 'natural feelings' or 'natural affection'. This fundamental moral

optimism mirrored their faith in the physically healing powers of nature; and since feelings could be seen as dependent on the body's physical organization without compromising a belief in free will, restoring their patients' bodies offered an alternative route to moral treatment to regulate their patients' minds.¹⁸⁸

Before looking more closely at the medical treatment offered by Charles Hayes and Samuel Newington, it seems important to look briefly at how they perceived the aetiology of mental disorders, and the diagnoses they used. An analysis of the 'supposed causes' of insanity given in the admissions books shows that in one third of cases the supposed cause was given as 'unknown', and that in those cases where a specific cause was given there was an almost equal distribution between 'moral' causes and 'physical' causes, with a slightly decreasing emphasis on 'moral' causes (see Table 30). Anne Digby has documented a similar decline at the Retreat; and Ticehurst was like the Retreat too in the fact that there was a decrease in the proportion of cases assigned to heredity. It seems likely that just as Quakers were sensitive to the issue of hereditary insanity because of their high rate of inter-marriage, the Newingtons were reluctant to assign 'heredity' as a cause to their upper-class and aristocratic patients.¹⁸⁹ Mayo had suggested that families were more loath to admit to insanity than

consumption in the family, but histories given in the case-notes make it clear that the Newingtons and their assistant medical officers were often aware of a family history of insanity, which did not necessarily lead them to assign 'heredity' as a cause in the admissions books. Indeed, since in some instances several generations of the same family were patients at Ticehurst, the Newingtons could not have been kept ignorant of these families' histories. Apart from Henry Winkworth and Louis de Visme, other admissions who were related to former inmates included: Charlotte Muggeridge, whose father had also been in the asylum; Francis Elwes, whose mother Jane Marianne had spent six months at the Highlands in 1851; and Jane Thompson, who was Sir William Walter Yea's grand-daughter. In 1863, an aunt and nephew, Julia and Timothy Brett, were admitted within two days of each other; and there were several lots of siblings in the asylum: David, Emily and Sarah Martineau; Caroline and George Simson; Lord Henry and Lady Maria Beauclerk; Alfred and Emily Lawford; and Lord Charles and Lord Frederick Hay.¹⁹⁰

Although degenerationist psychiatry was socially conservative in the sense that it provided a biological rationale for social inequalities, it could also be used by liberal critics of inherited privileges to argue for more open access. Thus in Fraser's Magazine in 1868

W.R.Greg wrote:¹⁹¹

Not only does civilisation as it exists among us enable rank and wealth, however diseased, enfeebled or unintelligent to become the continuators of the species in preference to larger brain ... but that very rank and wealth, thus inherited without effort and in absolute security, tends to produce enervated and unintelligent offspring. To be born in the purple is not the right introduction to healthy living. (Original emphasis)

Yet Greg was less willing to countenance the possibility of an hereditary factor in insanity amongst the middle-classes. Although Greg's wife Lucy Anne (1810-73) had been a patient at Ticehurst, there had been rumours that her father, the Manchester physician and chemist William Henry (1774-1836) had been insane before he committed suicide partly because of his anxiety at Lucy Anne's illness; and her sister Charlotte (1817-58) had been mentally defective; Greg, whose own brother Samuel was also incapacitated by chronic depression, attributed the prevalence of mental and nervous disorders amongst the middle-classes, like the increase in heart-disease, to the stress of their position in society.¹⁹² Anne Digby has rightly resisted the temptation to attribute the increase in the proportion of cases whose insanity was said to have been caused by 'anxiety' or 'overwork' to an increase in stress in an economically depressed mature capitalist economy, but it seems important to place these assigned causes within the self-perceptions of the mature Victorian middle classes. One of the first

admissions to Ticehurst whose breakdown was attributed to 'over-pressure of duties' by the former medical officer of Lincoln Asylum, Thomas Belgrave, was Samuel Hill, the former superintendent of a large county asylum in Yorkshire.¹⁹³

Compared with admissions to county asylums only a small proportion of admissions to Ticehurst were attributed to alcohol abuse. Differences between county asylums in this respect have been shown to parallel the strength or weakness of the temperance movement in different areas, and certainly rural Sussex was not an area of temperance strength; in addition, the Newingtons had a strong faith in the therapeutic value of alcohol, which will be elaborated below, and which might have mitigated against their willingness to see alcohol consumption as a significant causal factor in the onset of mental disorders.¹⁹⁴ Those whose insanity was sympathetically attributed to 'anxiety' or 'overwork' included some heavy drinkers, and it seems likely that, just as the Newingtons were reluctant to highlight a possible hereditary factor in their patients' insanity, they chose to describe alcoholism as a symptom of an earlier moral cause rather than as a physical disease.¹⁹⁵ More importantly, by choosing not to emphasise the role of alcohol abuse, which could be seen as a vice rather than a disease, they minimized any manifest moral condemnation

of their patients.

Although the evangelical moral values of the 1830s continued to be incorporated in some aspects of treatment at Ticehurst, at the point of admission the Newingtons were sensitive to their prospective patients' families own perceptions of what had precipitated the mental disorder, and largely echoed them. Evidence from outside Ticehurst would suggest that it was not uncommon for Victorian doctors to rely on what their patients or the patient's family told them of possible causes of the disorder. When H.Sieveking, who presented a paper to the Royal Medico-Chirurgical Society on the causes of epilepsy in 1857, was asked why he had not included masturbation as one of the causes, his somewhat embarrassed reply was that:¹⁹⁶

... it was not the assigned cause in any instance by the patient. The difficulty really was to arrive at the truth with respect to the influence of this cause in the production of the disease, and he confessed he did not know how to proceed to determine it in the case of females.

Thus when Charles Brett's insanity was attributed to 'self-abuse' in 1863, it was because his father had given it as the cause. Less close relations may have been more willing to countenance the possibility that heredity had played a part. The 'supposed cause' of insanity given on James Brook's certificates was 'congenital, aggravated by self-abuse', and Samuel Newington candidly told Brook's

brother-in-law Dearman Birchall after Brook's admission that 'the children of an epileptic father nearly always go wrong'. In addition, Samuel Newington counselled Birchall that in order to avoid the twin hereditary taints of insanity and consumption (of which Birchall's wife had died at the age of twenty one) affecting their daughter Clara, Birchall should '... not excite the brain until fully developed, ... [or] call for any mental exertion until a child is near ten years of age.'¹⁹⁷

When first admissions to Ticehurst are divided by gender, it is clear that 'moral' causes slightly predominated for male patients, and 'physical' causes for female patients, even though 'self-abuse' and 'intemperance' (the former exclusively and the latter more commonly given as causes of male patients' insanity) were counted as 'physical' causes (see Table 30.1).¹⁹⁸ Perhaps surprisingly, in the mid-nineteenth century female patients at Ticehurst were no more likely than male patients to have their insanity attributed to a broken or unrequited love-affair, as Anne Digby found female patients at the Retreat were, although their insanity was more likely to be attributed to a bereavement; male patients were seen as more prone to anxiety, particularly about business, or over-work (see Table 30.4).

The almost equal stress placed on 'moral' and 'physical'

causes of insanity neatly reflected the Newingtons', and their assistant medical officers', belief in the close inter-dependence and interaction of body and mind. The attribution of 'moral' rather than 'physical' causes did not imply a non-physiological pathology, or a more optimistic prognosis; any more than the attribution of 'physical' causes necessarily implied a pessimistic prognosis. As Bruce Haley has emphasised, in mid-Victorian psychophysiology mental un-ease and physical pathology, of bodily as well as mental disorders, were seen as mutually aggravating.¹⁹⁹ Thus in 1861 the disorder of a patient who was described on her certificates as 'morally insane' was said to have been due to 'cerebral disturbance'; whilst William Harcourt Ranking and Samuel Hill, who both suffered from progressive paralysis, had their disorders attributed to 'excess of mental occupation' and 'over-pressure of duties' respectively. In both these cases, the patients' paralysis was listed as a 'bodily disorder', but in most cases 'general paralysis' was given as the patient's mental disorder, particularly after the introduction of 'General Paralysis of the Insane' as a diagnosis.²⁰⁰

The influence of reflex physiology in emphasising the whole nervous system, rather than just the brain, in the physical pathology of mental disorders, was reflected in both the 'supposed causes' and the diagnoses made at

Ticehurst. Thus in 1858 Anne Farquhar's paralysis and mental disorder were attributed to falls during pregnancy which were believed to have 'affected spine, nerves of spine & spinal marrow'. Whilst in 1861 Ann Hopkinson's 'dementia senilis' was attributed to a 'womb and spinal disorder communicating with the brain'.²⁰¹ Although neither Charles Hayes nor Samuel Newington received a formal education in mental pathology, and both learned what they knew of mental disorders from their father, they did not adhere to Charles Newington's preference for simplicity in diagnosis. The admission books after 1850 reflected a proliferation of diagnoses which differentiated several types of 'mania' ('acute', 'hysterical', 'paroxysmal' and 'puerperal'), and included 'monomania'. In addition, Charles Hayes Newington diagnosed a patient in 1855 as suffering from 'chorea'; and nervous disorders like 'general paralysis' and 'epilepsy' began to be increasingly clearly differentiated (see Table 31). However 'delusions', the subject of which was sometimes specified, remained the preferred diagnosis until after the arrival of the assistant medical officers, who took over the role of diagnostician from Samuel Newington. It is worth noting that, as at the Retreat, 'imbecility' and 'weak-mindedness' were less frequently used as diagnoses (see Table 31).

The medical therapies employed by Charles Hayes and Samuel Newington were primarily supportive. No patients were venesected, although until the mid-1860s patients continued to be occasionally leeches to alleviate 'nervous irritation', particularly in cases of epilepsy or hysteria. Thus in April 1862, Frances Hoffman had twelve leeches applied to her temples after a particularly severe epileptic fit, which Samuel Newington described as 'apoplectic' in character; and in May 1863 Miss Jenney had two leeches applied to her spine to relieve 'spinal irritation'.²⁰² Although the Newingtons continued to purge patients, mostly with gentle purgatives like cod-liver oil, they also prescribed an increasing range of tonics, particularly iron and zinc compounds, including 'iron & strychnia', or the chalybeate Charles Newington had refused to prescribe to John Perceval.²⁰³ Patients were also given a 'full' diet, although in cases of 'nymphomania' this might be based on milk and cereals rather than meat. The persistence of the belief that patients with nervous and mental disorders had feeble constitutions and needed extra nourishment can be seen from the fact that in the 1870s the most common reason given for medical treatment in the medical journals kept at the asylum was 'debility'.²⁰⁴

Alcohol was prescribed as part of these supportive and

nourishing diets; and this practice had been endorsed by W.B.Carpenter in 1850 when he argued that alcohol was particularly nourishing to nervous tissue. Although the value of alcohol therapy became controversial in the 1860s when some physiologists argued that, contrary to the idea that alcohol built up nervous tissue, it was rapidly and totally eliminated from the body, it continued to be prescribed at Ticehurst. Two of the keenest opponents of the total elimination theory, F.C.Anstie and J.L.W.Thudichum, were amongst doctors who referred patients to Ticehurst in the 1860s.²⁰⁵ Even in cases where a patient was admitted suffering from delirium tremens after a bout of heavy drinking, alcohol in moderate quantities was prescribed, both for its putatively beneficial physical effects, and to cultivate a habit of moderation in the patient.²⁰⁶ In addition, alcohol was valued as a sedative, particularly as Samuel Newington remained dissatisfied with the use of opium for this purpose.

In their Manual of Psychological Medicine (1858) J.C.Bucknill and D.H.Tuke referred to opium as the 'sheet-anchor' of asylum doctors. However, although the Newingtons prescribed it both as a sedative and as an anti-nauseant, it was never their treatment of choice.²⁰⁷ When Lucy Anne Greg was admitted in 1857 she had been routinely sedated with opiates by her husband's sisters

whilst she was cared for by her family; but the Newingtons gradually reduced the amount she took, and regarded it as a sign of imminent recovery when she was able to sleep without a sedative. Similarly, when Mary Anne Foster was admitted in 1864 in a state of acute mania, she had not slept for six days and nights without morphia, and she had been restrained, bled and given no food. On arrival at Ticehurst she was bathed and given clean clothes, and then given food and an unspecified quantity of port wine, which enabled her to sleep for nine hours without morphia.²⁰⁸ The concern to find an alternative sedative to opiates informed Samuel Newington's only published article on medical practice, on the use of mustard-baths, which will be discussed below.

One group of disorders which remained stubbornly unameliorated by changes in diet was those which were characterised by fits, including epilepsy. In the 1850s and very early 1860s the Newingtons treated epilepsy with the anti-periodic quinine, with alcohol, or as noted above by bleeding.²⁰⁹ However, from 1863 they began to experiment with the use of bromides. Interest in potassium bromide had been aroused by the claims of Queen Victoria's physician Dr Locock in 1857 that he had successfully treated several epileptic patients with potassium bromide. Initially attracted to the drug for

its reputed anaphrodisiac effects, and unaware of its anti-convulsant properties, when Locock found that the patients to whom he prescribed bromides suffered fewer fits as well as stopped masturbating, he believed that he had proved conclusively that masturbation caused epileptic fits. Although R.H.Balme may be right to attribute the introduction of bromides at the National Hospital for Nervous Diseases to C.B.Radcliffe, it is clear from the case-notes at Ticehurst that, whilst Brown-Sequard did not mention bromides in his lectures on epilepsy in 1860-2, he advised Samuel Newington to treat Frederick Goulburn with 'large doses' of potassium bromide in October 1863 after Radcliffe had joined the National Hospital. A few months later Newington somewhat gloomily observed that this course had been '... persevered in without any beneficial result'.²¹⁰ Nevertheless, bromides continued to be prescribed at Ticehurst not only in cases of epilepsy, but in cases of 'nymphomania' and 'satyriasis', and most importantly as a general sedative. The experience of Thomas Belgrave at Lincoln Asylum had not alerted him to the dangers of 'bromism', which was first described in 1868. In the late 1860s at Ticehurst, very large doses were prescribed to some patients. Thus Jimmy Brook was given 90 grains a day; and in 1867 a female patient called Henrietta Unwin was prescribed up to 60 grains a day, despite the fact that she was pregnant.²¹¹ However, from the early 1870s

bromism began to be watched for in patients who were given bromides, and doses were reduced to 60 grains or less a day, since this was the level at which there was believed to be a danger that bromism might ensue; and patients who suffered an adverse reaction to even low doses of potassium bromide were given potassium iodide instead.²¹²

In his paper in the Lancet on the use of mustard-packs and mustard-baths in the treatment of insanity, Samuel Newington stressed that he had been tempted to experiment with the treatment in his search for an alternative sedative to opiates; he learned of the potential of mustard-baths through being treated himself at Matlock Baths, and later experimented on himself with the mustard-pack at Ticehurst. Newington described three modes of applying the mustard: firstly, as a paste of mustard and linseed-meal spread between muslin (to keep the skin clean) and brown paper, and tied over the abdomen; secondly, for a towel to be soaked in an infusion of mustard and then wrapped around the body and covered with a piece of macintosh; and thirdly, for 'five or six handfuls of crude mustard' to be added to an ordinary bath. He described several cases of acute mania where the patient had been calmed, either with the mustard-pack or the mustard-bath. The process by which Newington accounted for the calming effect of these

treatments reflected his fundamentally optimistic view of nature, and like Alexander Sutherland's account of the benefits of releasing maniacal patients from restraint, incorporated both a view of insanity as caused by congestion of the brain, and Carpenter's physiology, in this case of habit. Newington wrote:²¹³

As nature, aiming to restore the nervous element of the brain wasted by the day's labour diminishes the activity of the circulation through it ... so we, imitating nature, strive in this treatment of insanity to withdraw the excess of blood from the disordered brain ... And as when a morbid action continues for some time a habit of it is apt to be formed, and the habit to become a "second nature", so, on the other hand, whenever the morbid activity is interrupted, the tendency to revert to its sound type ... fails not to assert itself. (Original emphasis).

Although restrictions introduced by the lunacy commissioners of the number of hours for which wet-packs could be applied meant use of mustard-packs was virtually abandoned at Ticehurst, mustard-baths continued to be used, particularly to soothe maniacal patients who reacted badly to bromides. It is worth noting however that morphia also continued to be used to sedate patients in an acute state of mania.²¹⁴

Other baths which were used as part of therapy at Ticehurst also aimed to restore equilibrium to the patient's circulation. In states of mania, some patients were placed in a warm bath, whilst cold water was applied to their heads, to direct the blood away from the brain

and towards the rest of the body. The most common use of baths however was in treating women who suffered from ammenorrhoea, who were given warm hip-baths to draw blood to the pelvic region. In severe cases, these patients were also given aloes, as an emmenagogue rather than a purgative. The belief that suppressed menstruation contributed to insanity stemmed from the belief that insanity was caused by a congestion of blood in the brain, which it was thought restored menstruation might alleviate. Although this was a long-standing belief, and Mayo's writings and the earliest case-notes at Ticehurst make it clear that Charles Newington also attempted to regulate female patients' menstrual cycles, in the early 1860s a renewed emphasis began to be placed on the importance of women's reproductive physiology.²¹⁵

The way in which this shift was reflected in the certification procedure has already been noted (see Table 30.4). What it seems important to bring out here are the connections between this change and the development of a new profession of gynaecology. New surgical techniques in the mid-1860s meant that, if the doctors' assumption of a particularly close link between women's minds and their reproductive organs proved correct, new heroic strategies of treatment might be developed. That psychiatrists began to be in competition with gynaecologists may be gauged from the fact that a young

medical man with the prospect of a promising career in asylum medicine might opt instead to become a gynaecologist: Dr Edis' decision to do this after he left Ticehurst led to a lucrative practice in Wimpole Street from which he acted as a consultant gynaecologist to patients at Ticehurst in the late 1870s.²¹⁶ Increasing numbers of female patients and their families had consulted gynaecologists in their search for health and well-being before they consulted doctors who were specialists in psychological medicine. To have a minor anatomical or physiological disorder one peripheral symptom of which was some emotional disturbance was less stigmatizing than to acknowledge a frankly mental disorder; and attributing a woman's mental disturbance or distress to a localized physical disorder could alleviate families' guilt and anxiety about what was wrong with the patient, as well as holding out hope of a cure.

Samuel Newington's way of countering any possible competition with gynaecologists was to include gynaecological consultance amongst the range of facilities which were accessible to patients from Ticehurst. Just as he consulted physicians at the National Hospital in cases of epilepsy, any patient with a suspected gynaecological disorder brought a consultant gynaecologist from London. The belief that disorders of the uterus or ovaries could cause mental disorders was

based by the 1860s primarily on the idea that local 'irritation' of those organs could create excessive 'irritation' in the whole nervous system and brain.²¹⁷ Thus in 1867 a patient called Mrs Welstead, whose acute mania was attributed to her prolapsed uterus, was mechanically restrained whilst she was fitted with a pessary: her condition showed no sign of improvement, and after she removed the pessary herself the day after it had been fitted, she was not fitted with another. However, patients continued to be fitted with pessaries in an attempt to alleviate their mental condition until the late 1870s.²¹⁸

The desire to find a localized physical cause for their disorders, and to avoid certification, was shared by male patients and their families. Before his arrival at Ticehurst Herman Charles Merivale (1839-1906), whose autobiographical account of his illness insisted it had arisen from grief at his father's death, a disturbed liver and abuse of chloral hydrate, had stayed at a hydropathic establishment. Although he was dosed fairly heavily with potassium bromide during a period of mania whilst he was at Ticehurst, like Perceval Merivale remembered Ticehurst as a place where little medication was given. It is possible that Merivale's memory of his illness was incomplete; or, as with Perceval, that he was given medicine without being aware of it. Whichever

explanation is correct, Merivale also noted, in contrast to Perceval, that the doctors were willing to give patients any medicine they asked for. Yet this ought not to be taken at face-value: it is clear from case-notes in the 1860s that hypochondriacal patients, as Merivale was, were readily given placebos to calm their anxieties about their health.²¹⁹ Altogether, expenditure on medicines in 1880 amounted to £81.10s., significantly more than that described by Anne Digby at the Retreat.²²⁰

As this last example shows, there were many ways in which medical and moral treatment overlapped. In a letter to Samuel Newington in 1861, Harrington Tuke described one patient's medical treatment prior to her admission to Ticehurst as having been directed 'to local symptoms and to the general health', and this was a concise summary of what Samuel Newington believed medical treatment could achieve.²²¹ Yet as Bruce Haley has argued Victorian psychophysiology taught that:²²²

If the disease begins with a state of psychic disorder, the restitution of health might begin with a natural and orderly physical life.

Whilst moral therapy was the only specialist treatment asylum physicians had to offer, the claim of asylum doctors to a special expertise in treating the insane stemmed not only from a rhetorical assertion that insanity was a brain disease, but from the belief that as general physicians they had a specialist knowledge of how

to regulate the whole body, which was the physical vehicle of the mind.

4) The Asylum and the Outside World

To what extent were the Newingtons successful in convincing their potential clientele that this combination of moral therapy and general medical treatment offered the best available chance of a cure? The medical profession's helplessness in the face of repeated epidemics of cholera, typhus, typhoid and influenza in the 1830s and 1840s had left public confidence in the curative capabilities of the medical profession, even of physical disease, at a low ebb; the consumers' shrinking from the painfulness of drastic bleeding and purging, if they could not bring the hoped-for cure, as well as the physicians' own crisis of therapeutic confidence, provided one of the motors of change from 'heroic' to stimulative and supportive therapies. One advantage of Ticehurst's emphasis on a homely, rather than a hospital-like, ambience and design was that it escaped some of the negative connotations of hospitals as gateways to death. As Nancy Tomes has emphasised of mid-nineteenth century America, the middle and upper class clientele who sought private asylum care for their insane relatives would not have considered hospitalization for the treatment of a physical illness. An appeal to a physical pathology of insanity provided a

rationale for the medical profession's involvement in the treatment of the insane, but amongst the middle and upper classes a medical model would not necessarily foster an acceptance of institutional treatment.²²³

The scrupulous cleanliness and nourishing diets at Ticehurst minimized the risk of infections, and only one patient was recorded as having died there from typhus, in the early 1840s.²²⁴ Perceval, who accepted the miasmatic theory of cholera's causation (or, as he expressed it, believed that the disease was caused by 'inspiration') had asked his family to send him a bottle of aromatic vinegar to protect him against cholera when he was a patient at Ticehurst in 1832; but in fact Sussex was one of the six counties which remained unaffected by the cholera epidemic of 1832, and no deaths occurred at Ticehurst when cholera reached Sussex in the epidemic of 1848-9.²²⁵ Of at least equal importance to the fear of infection to the public image of private asylums were memories of the abuses described in the 1815-16 select committee reports, as well as continuing revelations of over-crowding and under-nourishment such as those concerning Haydock Lodge Asylum in 1846.²²⁶ Despite the impact of moral treatment and non-restraint on the ethos of asylums, and regular inspection by the visitors and the lunacy commissioners, public confidence in the good-will of asylum proprietors, and the quality of

private asylum care, remained poor. If the worst revelations concerned pauper patients, regular inspection by the lunacy commissioners created new anxieties about the possible loss of privacy which would result from government regulation.

There is ample evidence from Victorian letters, diaries and autobiographies that upper and middle class families feared asylums as much as they feared hospitals, and had low expectations of the kind of care their relatives might receive there. In July 1843, before Henry Winkworth's admission to Ticehurst, his younger sister Catherine (1827-78) visited Lancaster Prison, and noted in her diary that 'no sight can be more painful unless it be a lunatic asylum'. Her subsequent imaginative description of what she believed an asylum would be like was edited out of the published journals by her sister Susanna, but such fearful fantasies must have made it difficult for Catherine to come to terms with Henry's confinement two years later.²²⁷ Personal inspection did not always allay families' anxieties about institutions. When the novelist William Thackeray's wife Isabella became suicidal after the birth of their third child in 1842, he contacted one of the lunacy commissioners, Bryan Procter (1787-1874), for advice about asylums. Later, William wrote to his mother that 'Procter ... took me to his favourite place which makes me quite sick to think of

even now. He shook his head about other places.'; and they eventually made private arrangements with a Mrs Bakewell in Camberwell.²²⁸

Single confinement outside the home was only one of a possible range of alternatives available to upper and middle class Victorians who chose not to opt for asylum care. Patients who were eventually admitted to Ticehurst had sometimes also spent time being treated at home, often with a private nurse or attendant, or been sent on trips abroad in an attempt to cure them of their disorders. Reluctance to resort to asylum treatment before other options had been exhausted explains why first admissions to Ticehurst were on average older than first admissions to some other asylums. A Letters Book which recorded applications for admission between 1857 and 1873 occasionally noted a family's last-minute reluctance to have the patient admitted to an asylum as the reason why a prospective patient had not been admitted.²²⁹ Equally, patients who failed to improve at Ticehurst might be removed to a different form of care rather than another asylum: over 40% of first admissions to Ticehurst between 1 August 1845 and 31 July 1885 were discharged 'relieved' or 'not improved' rather than 'recovered', but less than one quarter of these were immediately transferred to another asylum or single medical care (see Figure 11).²³⁰

The case-history of a patient called Washington Travers illustrates some of the non-medical options which were available. Initially admitted to a small private asylum in Guildford, Washington Travers improved sufficiently for Dr Sutherland and a Dr Benjamin Travers (no known relation) to recommend a period of travel abroad to confirm his recovery. He became a student at Queen's College, Gallway, and travelled from there with one of his professors to Koblenz; but whilst there he became violent, and was arrested by the Swiss police, spending a short time in an asylum on the continent before being transferred to Ticehurst. After being a patient at Ticehurst for sixteen months, he was placed in single confinement with a Revd Cawithen in Devon in January 1856. However, when he ran away to his brother's in London, went to where the Prince of Wales was bathing, laughed at him and called him names, Travers was returned to Ticehurst in July 1858. From there, he was allowed out several times on trial, spending the Christmases of 1858 and 1859 on the Isle of Man with a friend, and part of the summer of 1859 in Scotland with his cousin. In April 1860, he left for Australia with an attendant, and travelled for about eight months, coming back via Shanghai and Japan. Shortly after his return he was discharged from his certificates and went back to Australia, where he planned to stay for five years.²³¹ As is clear from this example, although psychological

physicians advocated early asylum treatment, they might recommend travel abroad after a patient's condition had improved. More general practitioners sometimes advised patients to go abroad rather than seek asylum care. Thus Herman Charles Merivale claimed one of the doctors he consulted had somewhat melodramatically told him to "Travel,... do anything rather than give way. If once you find yourself in an asylum, Heaven help you!"²³² But the emphasis on will in early-Victorian medical psychology naturally lent itself to adjurations to the patient to pull themselves together.

Doubts about the therapeutic effectiveness of orthodox medicine had opened the market to heterodox practitioners, such as mesmerists, homeopaths and hydropathists, who treated patients at home or in their own establishments. As Terry Parssinen has argued the people who patronized these 'medical heresies' in the 1840s were 'an affluent, urban clientele': precisely the kind of people who might otherwise have sent patients to Ticehurst.²³³ Mayo had expressed interest in mesmerism's therapeutic potential, and the homeopath John Epps had been satisfied with the treatment his friend Joshua Mantell received at Ticehurst; but despite his own use of baths and interest in hydropathic treatment, by 1860 Samuel Newington's attitude to heterodox practitioners was frankly critical, and he described the Unitarian

minister George Kenrick as having been 'subjected' to hydropathic and homeopathic treatment before his admission to Ticehurst.²³⁴ Yet if the Newingtons' potential clientele feared and shunned hospitals, some of them did patronize the spas, bathing-places and new hydropathic establishments which sprang up all over Europe in the first half of the nineteenth century; and although the shame aroused by insanity meant that patients travelled to Ticehurst to be hidden rather than to be seen, the luxurious pampering of incurable complaints in establishments which were run like hotels rather than hospitals provided an alternative prototype to the hospital which the Newingtons could emulate in their own practice.

Despite mesmerism's particular claim to the successful treatment of nervous disorders, there is no evidence of patients being treated mesmerically before admission to Ticehurst. One patient admitted in January 1837 had his certificates signed by John Elliotson (1791-1868), but this was before Elliotson began his famous mesmeric experiments. Patients' awareness of the vogue for animal magnetism can be gauged from the fact that in the 1840s and 1850s several of them attributed their disorders to mesmeric interference.²³⁵ Although there is no evidence that any of these patients had actually been mesmerized, the therapeutic scepticism which attracted patients to

unorthodox medicine could make them fear that any attempted remedies might be ineffective at best, and at worst positively harmful. In cases where the patient's symptoms did not lead to ostracism, such disillusion could lead to a total rejection of treatment. To give an example, William Rathbone Greg's brother Samuel (1804-76), a reformist mill-owner, suffered a nervous breakdown in 1846 when the introduction of new stretching machinery to his mill at Bollington in Cheshire led to a walk-out by staff. He suffered from debilitating depression, did not go out for nine years, and was never able to resume management of the mill. Attributing his ill-health to the phreno-mesmerist experiments he had undertaken with William in the 1820s, Samuel Greg believed his nervous system had been irreversibly depleted of energy. Initially trying hydropathic treatment at Malvern and on the continent, he 'suffered many things from many physicians, but with little help or satisfaction, and came to feel that he must sit down under his burden and live with it as best he could to the end.'²³⁶ Despite the Newingtons' successful treatment of William Greg's wife Lucy's long-standing disorder in the late 1850s, and W.R.Greg's subsequent recommendation of Ticehurst to family and friends, Samuel Greg never became a patient at Ticehurst.

Resignation like Samuel Greg's required tolerance and

fortitude from the sufferer's family and friends. In acute cases, or when someone became suicidal or violent, it was simply impracticable. It was George Kenrick's volatile temper and attempt one night to conceal a razor in his bed (with what were presumed to be suicidal intentions), which persuaded his wife Sarah that homeopathic and hydropathic treatment at home offered insufficient protection in his case, so that she agreed to his certification.²³⁷ The advantage which homeopathic and hydropathic treatment had over certification was that they could be addressed to treating whatever physical disorder was believed to be affecting the patient's mind, thereby avoiding the stigma of mental disease. In his evidence to the select committee on the lunacy laws in 1877, James Crichton Browne alleged that many insane patients were illegally confined in hydropathic establishments to avoid the stigma of certification.²³⁸ Certainly patients who considered themselves 'nervous' rather than insane might opt for treatment at a hydropathic establishment rather than an asylum. As noted in the previous section, Herman Charles Merivale, the son of the permanent under-secretary of state for the colonies and India, had sought treatment at a hydropathic establishment before being admitted to Ticehurst; and he attributed his ultimate breakdown to the enervating effects of this unsuccessful water-cure and the reduced diet dictated by his disturbed liver, as well as grief at

his father's death and excessive medicinal use of chloral hydrate. In his autobiographical account of his confinement at Ticehurst, Merivale described the loss of self-esteem which certification and involuntary confinement entailed for the patient, noting that 'The feelings of fear and shame - for it had in one's own despite a sort of shame about it - that the experience left behind, died slow and hard.'²³⁹ His own feelings of shame were sufficiently acute for him to publish My Experiences in a Lunatic Asylum by a Sane Patient (1879) anonymously, despite its blustering title; just as John Perceval had initially published his Narrative anonymously because he was 'ashamed of his late calamity'.²⁴⁰

The shame experienced by families when one of their members went insane could also be very intense. Susanna Winkworth's biography of her sister Catherine described the close and affectionate relationships enjoyed in their evangelical family. Yet although the biography was privately printed for circulation within the family only and referred to physical illnesses and treatment experienced by various members of the family, the eldest brother Henry, who was confined at Ticehurst, was never mentioned by name. References in Catherine's diaries which circumstantial evidence would suggest were to him were represented by asterisks, and he was described in

the footnotes simply as 'a close connection'.²⁴¹ Such shame and embarrassment may have been particularly acute when families placed a high premium on intellectual achievement. In a letter to Eliza Fox in February 1853, Elizabeth Gaskell remarked bitingly of Susanna Winkworth that she had been 'wiser than ever since the Times said she was no average woman'.²⁴² Yet this personal vanity was underpinned by the extent to which Susanna relied on her intellectual reputation (as translator of the life of Niebuhr) to maintain her social position. The decline of the Winkworth family's silk-manufacturing business had created financial problems. In 1859, Susanna's younger brother Stephen took over her housekeeping expenses so that she could afford to pay her doctor's bills. Although the Ticehurst accounts do not record how much was paid for Henry Winkworth (partly because some of his time was spent at the more costly Highlands), even if he had been paying average fees in the mid-1840s of three guineas a week, his annual bill would have come to more than the £100 per annum his father eventually felt able to bequeath for his upkeep in 1869.²⁴³ Of course, having a son who was chronically dependent in this way must have contributed to the family's financial problems.

If anticipated shame and embarrassment was one reason why patients and families might resist or postpone certification, as happened in Herman Charles Merivale's

case, these emotions could also make a family eager to remove a patient from their family circle, in order to conceal their disorder. Amongst the middle and upper classes, apart from criminal cases which went through the police and courts, it was families and friends who made the initial diagnosis of 'insanity' by referring someone for treatment, and most admissions to Ticehurst were there on the authority of one or more of their family (see Table 34). As appears to have been the case since Ticehurst opened, men more commonly assumed the legal responsibility for referring patients of both sexes than women. When women did refer patients it was sometimes made clear that they derived the authority to do so from their husbands. Thus in 1876 a woman called Amelia Pretyman referred her sister-in-law Emily Pretyman 'on behalf of her husband, Revd J.R.Pretyman, clerk in holy orders, Bournemouth'.²⁴⁴ Although the admissions certificates and histories in the case notes do not make it possible to build up a detailed picture of the family's internal process of decision-making, they do indicate the kind of behaviour which families found so intolerable, disruptive or disturbing that they were willing to resort to certification, despite the stigma it carried.

Violence to people or property, and threats or attempts of suicide, were amongst the most common reasons given

for certification, perhaps partly because danger to one's self or others were recognized in law as sufficient reasons for depriving a person of their civil liberties. Thus in September 1845 Pauline Folliau, who was described as neither suicidal nor dangerous to others, was nevertheless certified after 'violent behaviour, breaking furniture, burning her clothes, accusing her parents of injustice & ill-treatment ...'; and Charles Rawdon was admitted in October 1846 after he had '... armed himself with loaded pistols with the intent to shoot a person besides frequent threats of the same kind against other individuals & many other similar acts of violence'. Anna Direy was confined when she slashed her arm with a razor in a suicide attempt in June 1849 because she 'cannot safely be left alone'; and in May 1856 Edward Lloyd was diagnosed as suffering from 'suicidal melancholia' two days after he had 'made an attack on his wife with a pen-knife making two wounds of a serious character'.²⁴⁵

Other patients had become unmanageable at home because of their tendency to wander away from home, or cause disturbances locally. Thus in July 1848, seventy-eight year-old Elizabeth Winsor was confined because of 'her general dislike of friends, disinclination to take food, & a constant desire to leave her house & wander about & wish to see her brothers & others who have been dead a long time'; and in August 1856 Revd Patterson had:²⁴⁶

left his father's house in the middle of the night with only his shirt-drawers & travelled for a distance of a mile & a quarter to a neighbour's house declaring that his brother was persecuting him.

However, it was only after Patterson had also been evicted by his landlady, left by a private attendant who 'could not endure his [Patterson's] abuse', and boarded in single confinement without any improvement in his condition, that his family agreed to his being admitted to Ticehurst six months later.²⁴⁷ As well as being violent, Arthur Basset, who became a patient at Ticehurst in March 1856, was described as 'wildly incoherent in his manner & conversation ... often howling and screaming'; but violence was the more crucial factor in deciding on certification.²⁴⁸ Fifteen months before James Brook's family seriously considered certifying him, Dearman Birchall described Brook as looking 'half demented ... as if he could not bear the light - and he had been howling and larking on horseback with Miss Hirst'; but the final decision to confine Brook was taken only after he had become:²⁴⁹

... very violent, feared treachery, spoke of murder and suicide, and seemed to take a terrible horror of me [Dearman Birchall] and his uncle. He threw bread violently at Lillie calling her a murderess. He said he was W. Leigh Brook of Meltham [his father] and had twice attempted his life.

Delusions and forms of behaviour which were not acutely disruptive might be tolerated for some years before

certification was considered. For W.R.Greg, a unitarian and author of the widely discussed Creed of Christendom (1851), the fact that his wife's delusions centred on religion created social embarrassment. After her year's stay at Ticehurst, Lucy Greg was still not free of the 'delusion' that she was a Roman Catholic. Whilst staying with the Gregs in 1859 Susanna Winkworth confided to her sister Catherine that:²⁵⁰

Mrs Greg is such a sweet creature ... but evidently very weak and can't bear much talking ... it was awkward in our talks that I don't know, and can't make out whether she is Protestant or Catholic.

Mrs Greg finally openly went over to Rome in 1867; but clearly by itself this kind of embarrassment could be tolerated within her family circle. Lucy Greg had spent a short time in Brislington House in 1842, but for several years before she was confined to Ticehurst, despite her religious convictions and periodic delusions, she had lived in a cottage near her family where she was nursed by William Greg's sisters, 'occasionally enjoying the intercourse and society of her domestic circle', and she was only certified in 1857 after she had also become violent.²⁵¹ In chronic cases like Lucy Greg's asylum treatment could be resorted to to protect the family from the patient's most extreme symptoms, and relieve them of the burden of caring for a chronically insane relative, rather than with strong hopes of obtaining a cure; although in Lucy Greg's case the Newingtons were able to

wean her off the opiates with which she had been sedated at home, and discharge her 'recovered' at the end of a year.²⁵²

More basic breaches of social decorum were less easily tolerated. Although, as was described in the previous section, Anne Farquhar's family continued to nurse her at home for several years before she was admitted to Ticehurst, despite her resistance to personal cleanliness, dirtiness and neglect of appearance alerted some families to the possibility that a prospective patient was unable to take proper care of themselves. Thus George Wood, who was certified in April 1853, seemed 'unconscious of eccentricities which have long prevented the possibility of his living with his relations ... for many months he has neglected all habits of Cleanliness'; whilst four years later Thomas Wright was confined because he refused to eat, and was 'refusing to conform to any of the usual rules of society and neglecting to dress himself'. In April 1860 the main reason given for Eliza Gipps' certification was that:²⁵³

she entertains the delusion that when obeying the calls of nature her life is passing from her and therefore retains them as much as possible & is very dirty in her habits.

After over six years at Ticehurst James Brook was no longer violent, but when Dearman Birchall visited him at St Leonards, Brook:²⁵⁴

... walked about laughing in a most idiotic fashion. He bites his nails, sucks his thumb and spits. His general effect affords no grounds for encouragement. He made no observation and declined a more intelligible answer to our enquiries than a grunt.

and his relatives do not appear to have considered removing him from Samuel Newington's care at this time.

Just as obscene language and manifestly sexual behaviour were seen as negative symptoms in Ticehurst, both featured amongst the reasons why patients were originally confined. Thus in 1855 Mary Turney was admitted to Ticehurst because she had delusions, refused food, and '[used] foul language'. Frances Willington was described on her certificates in 1853 as 'labouring under nymphomania'; and Henry Shepherd's 'general conduct especially towards females' was said to be 'not that of a sane person'. In 1858 Isabella Foster was certified after she 'made an attempt upon the life of one of her children, ... [and] exposed herself naked several times'; and she was also described as 'making use of very foul language'.²⁵⁵ In some cases, expressions of sexuality were found to be particularly disturbing because they were seen as inappropriate socially: apart from the case of Augustus Gawen described in the previous section, who had proposed marriage to a fisherwoman, Henrietta Golding was admitted in April 1847 after she had 'shewn strong inclinations to form an improper connection with a Person

of very inferior grade'; and Charles Mawley, who was later removed from Ticehurst because he annoyed other patients, was confined partly on account of his 'keeping low company' and making 'Indecent conversation in the presence of ladies'.²⁵⁶ However, evidence from Ticehurst suggests that, although Charles Hayes Newington particularly valued sexual and social propriety, certification could not easily be resorted to by middle and upper class Victorians as a means of sexual and social control when no other 'symptoms' of insanity were present.

Whilst staying for her health with a Dr Smith in Ilkley Wells, Henrietta Unwin, who later became a patient at Ticehurst, alleged that the doctor had sexually assaulted her whilst she was 'unconscious'. On hearing this, her husband removed her from Dr Smith's and took her to Brighton. From there, Mrs Unwin ran away to her mother's in Essex, where she cut off her hair and dressed in a man's clothes before travelling to London. Taken back to Essex by her husband, she again ran off to London, and from there to Paris. On the channel steamer she met a man with whom she spent the next three or four days in a hotel in Paris, before applying successfully for a position as English governess with a French family. When her husband discovered where she was, he went to fetch her, and took her back to Brighton where he attempted to

have her certified. In April 1861 she was admitted to Ticehurst, and although notes made on one of her later re-admissions suggested that she was not confined at this time because her husband could find only one doctor to sign a certificate, the admission book listed two referring doctors, who had diagnosed her as 'morally insane'. However, no case notes were made on this admission, and she was discharged one week later 'not improved'. In 1864, Mr Unwin again brought his wife to Ticehurst village in the hope that he could get her admitted to the asylum, but, despite the fact that it was a common practice for prospective inmates to be certified by local doctors after they had been brought into the locality, he was unable to find two doctors who were willing to certify her.²⁵⁷ Finally in February 1866 her husband succeeded in finding two doctors to sign the necessary certificates, and Henrietta Unwin became a patient at Ticehurst for the next nine months, during which time the unusually brief notes which were kept on her case suggest that she 'never exhibited the slightest symptom of intellectual insanity'.²⁵⁸

It is unclear why Henrietta Unwin was discharged in 1861 after only one week, but in view of her husband's later persistence in seeking to have her re-admitted it seems unlikely that it was at his instigation. One possibility is that the Newingtons believed her to be sane, and were

thus reluctant to have her as a patient, particularly at a time when the public controversy over alleged wrongful confinements in private asylums which surrounded the 1858-9 select committee on the care and treatment of lunatics would still have been fresh in their minds. It must have been a cause of some embarrassment to the Newingtons that as secretary to the 'Alleged Lunatics' Friends Society (founded in 1845) John Perceval, who openly accused Charles Newington of having detained him at Ticehurst longer than was necessary from mercenary motives, was a prominent witness at this inquiry.²⁵⁹ However, Henrietta Unwin was discharged 'not improved' rather than 'cured'. Although there is no hard evidence that the Newingtons asked her husband to remove her, a second possibility is that they were troubled by her allegations concerning Dr Smith.

In the summer of 1858 a widely-publicized divorce suit by a Mr Robinson had cited his wife's hydropathic physician, Dr Edward Lane, as co-respondent. A successful hydropathist, whose patients included Charles Darwin, Lane managed to get the case dismissed, partly because he was able to prove that it was his usual custom to walk in the grounds of his hydropathic establishment with his female patients, and therefore that his having done this with Mrs Robinson did not imply an adulterous relationship. Although Lane's practice apparently did

not suffer once the case had been dismissed, an editorial in the British Medical Journal in June 1858, before the verdict was given, expressed fears that, even if the divorce suit failed, Lane's practice might suffer, and that although '... we cannot be expected to sympathize with hydropaths particularly, ... his case may be our own any day'.²⁶⁰ Like Mrs Robinson, whose diary descriptions of her alleged affair with Dr Lane were dismissed as fantasy by medical witnesses who included Forbes Winslow and Charles Locock, Henrietta Unwin was described in notes on her case at Ticehurst as suffering from 'ovarian irritation'.²⁶¹ The appointment of an assistant medical officer, and Samuel Newington's increasingly distant relationships with his patients, may have made him less fearful of such damaging allegations having any chance of being upheld, and more willing to admit Mrs Unwin as a patient in 1866. It seems important to emphasise here that Samuel Newington's fear was not so much of the vigilance of the lunacy commissioners (whose moral outlook he shared) but of a watchful public opinion, which could be equally critical of a perceived abuse of civil liberties and of any imagined moral laxness. Peter McCandless is right to stress that the Victorian debate over moral insanity and wrongful confinement (like that over marriage which surrounded the introduction of the new divorce law in 1857) provides a sensitive barometer of the ethical tensions and pluralism which existed

within British society in the 1850s-60s.²⁶²

Samuel Newington's fundamental sympathy with Mr Unwin is suggested by the fact that in 1864, when Mr Unwin could not find two doctors to certify his wife, Newington arranged for Mrs Unwin to be lodged in Ticehurst village. The exact nature of these lodgings is unclear, but although no formal certification or admission was made, according to the letters book which recorded applications for admission to Ticehurst, Mrs Unwin 'came 18th November 1864 & went to W.Balcombe'.²⁶³ Just as the first Samuel Newington had boarded out violent and refractory patients in Ticehurst village, the most plausible explanation for the younger Samuel Newington's involvement in finding lodgings for Mrs Unwin would be that, like Alexander Sutherland and Forbes Winslow, he endorsed some private lodgings for single patients in the local area. However, by the mid-nineteenth century it was those patients whose status before the law was most ambiguous, rather than those who were most violent, who were likely to be confined in single lodgings. The very small extent of this practice in Samuel Newington's case may be gauged from the fact that in 1870 his total income from 'out-patients', who would have included former inmates sent out on trial, was only £9.4s.0d..²⁶⁴

Despite the evident potential for an abuse of civil

liberties which arose from the still extensively unregulated private lodgings for single patients, following John Perceval's cue it was this type of care which the Alleged Lunatics' Friends Society advocated as preferable to asylum treatment, with the important difference that they wanted as many patients as possible to be voluntary. Both Perceval and (later) Merivale emphasised in their accounts of their illnesses that they had known that they were in need of treatment, and that the sense of humiliation which resulted from being stripped of their autonomy through certification, and which persisted long after they had recovered, would not have occurred in a system which made provision for voluntary treatment.²⁶⁵ Nicholas Hervey has rightly argued that Perceval's faith in private, preferably small-scale, care stemmed both from the high evaluation of confidentiality which was traditional to his class, and from a fear of the regimentation of care which seemed inevitable in large-scale institutions: the Society's interest in the lunatic colonies at Gheel suggests that they were keen to extend a more socially diffuse system of care to pauper, as well as private, patients.²⁶⁶

Although voluntary admission was not included in the new lunacy legislation, from 1862 it became legal for patients who had recovered sufficiently to be released from their certificates to stay on at private asylums as

voluntary boarders (25 & 26 Vict., c.111). In 1856 when the lunacy commissioners had considered the exceptional circumstances of a patient called Miss Thorpe, who '[had] no home & express[ed] a wish to remain here [at Ticehurst]', the Newingtons had opposed the board's suggestion that she should 'reside here as a boarder'.²⁶⁷ However once the practice had been regulated some patients did stay on as voluntary boarders, like a Mr Sullivan who felt he lacked the 'nerve' to leave Ticehurst in February 1873, despite Samuel Newington's willingness to discharge him.²⁶⁸ Apart from the personal embarrassment caused by Perceval's outspoken criticisms of Charles Newington, and the A.L.F.S.'s involvement in the case of a patient called Captain Childe, who was moved to Ticehurst from Hayes Park in 1854, the Society's activities posed only a limited threat to the Newingtons.²⁶⁹ However, the more persistent campaign of the Lunacy Law Reform Association (founded in 1873) to completely abolish private asylums brought Samuel Newington's work at Ticehurst under much closer public scrutiny.

In all, the cases of at least five patients at Ticehurst were discussed by members of the L.L.R.A.: Sir Samuel Fludyer (1799-1876), John William Thomas, Thomas Preston (d.1877), Walter Marshall (b.1837) and Herman Charles Merivale. Of these, the cases of Thomas, Preston and

Marshall were taken up by the select committee which conducted an inquiry into the operation of the lunacy laws in 1877, at which Samuel Newington was called to give evidence. In August 1873, Thomas Preston had written to the secretary of the L.L.R.A., Louisa Lowe (1821-1907), from Ticehurst alleging that his brother, who had sole control of Thomas' estate under an order of the Chancery Court, would not allow him any money to appeal again to the court to establish his sanity and regain control of his affairs. Certainly by September 1874 Preston 'seemed perfectly sane' to Dearman Birchall, who was one of the visiting magistrates at Barnwood House to which Preston had been transferred in December 1873; and he was well enough to follow up Birchall's visit with a letter which Birchall described as '... very clever, containing an amusing account of Dr Newington who considers Ticehurst a paradise on earth and wonders everybody does not rush in to be confined'. In addition, a former attendant at Ticehurst Robert Minchin, told the Association that Preston had appeared sane during his three years confinement at Ticehurst, and that 'he [Minchin] also knows of other persons at Ticehurst perfectly quiet and harmless'. However, only one witness who was called to give evidence to the select committee volunteered the opinion that Preston had been 'perfectly in his senses' whilst he was confined at Ticehurst: Preston's former fellow patient, John Thomas. In

defending Preston's confinement, and advising against his liberation, all of the medical witnesses, and Charles Palmer Phillips, secretary to the lunacy commissioners, emphasised the fact that Preston's history included criminal assaults on women, the exact nature of which remained unspecified; Preston himself was not called to give evidence.²⁷⁰

Whilst the question of Preston's alleged insanity must thus remain open, Samuel Newington was able to turn the enquiry by the select committee to his own advantage. Emphasising that Preston had been a friend of his whilst he was a student at Oxford, Newington simultaneously assured them select committee of his own gentlemanly credentials, and of his good intentions towards Preston. The overall impression created by the evidence given by John Thomas was that he owed his recovery to Samuel Newington, since he attributed it to the full diet he had been allowed at Ticehurst, in contrast to the reduced diet he had been kept on at Sussex House. In his evidence on Thomas' case however, Newington closed ranks with Forbes Winslow, suggesting that Thomas' recovery had begun at Sussex House, before his transfer to Ticehurst. Thomas claimed that he had been detained longer than was necessary after his recovery rather than that he ought never to have been confined, but Newington gave evidence that it was Thomas' family, rather than he, who had

opposed Thomas' discharge from Ticehurst, and this was upheld by Charles Palmer Phillips.²⁷¹

The Newingtons role seems to have been less ingenuous in the one case from Ticehurst on which Samuel Newington was not asked to give evidence, that of Walter Marshall.

Although on admission Marshall was diagnosed as suffering from general paralysis, and must have been expected to become a long-stay patient, he told that select committee how, after he had been at Ticehurst for a few days, where he believed he was wrongfully confined, 'Dr Newington' (possibly Herbert Francis Hayes, who kept Marshall's case notes, rather than Samuel) suggested that if he co-operated with the treatment at Ticehurst he might soon be discharged. Marshall recalled:²⁷²

I told [Dr Newington] all my case, and he talked very kindly. Of course, I told him all. I treated him with perfect confidence. He said, "Well, your former life shows that you require some medical treatment; suppose you stay here for six weeks; I understand your case. By that time you will get out perfectly well; and there will be no scandal or anything." That was reasonable, and I consented to that.

Yet two weeks later, after the Prince of Wales' physician Sir William Gull (1816-90) had confirmed Hayes Newington's diagnosis whilst he was at Ticehurst to visit another patient, Marshall's family and friends were told he would 'never leave Ticehurst'.²⁷³

It is possible that Hayes Newington was genuinely cautious about the certainty of the diagnosis he had made. Although Walter had, in Hayes Newington's choice of word, 'confessed' that he had been treated for syphilis eighteen years previously, contemporary medical opinion viewed syphilis and general paralysis as independent diseases, seeing syphilis as only one of several predisposing causes of general paralysis. The first case notes kept on Walter Marshall described him as relatively rational. They commented that: 'His memory seems to be fair, he is quite coherent, and though he has not expressed any definite delusions, yet there seems to be working about him some idea of greatness'. He was 'never idle', and within two days of admission had 'already painted some fairly executed pictures of the grounds etc.'. The medical treatment he was given consisted of iodide of potassium, commonly used to treat syphilis. However, after Gull had concurred with Hayes Newington's opinion that Marshall's tremulous facial muscles and exalted state of mind were symptomatic of the first stage of general paralysis, even Marshall's paintings were viewed in a different light:²⁷⁴

His room ... is decorated with very many of his own paintings and drawings, mostly of a gaudy, sensational and jerky character. Some present the typical G.P. appearance - lots of colours grouped into purposeless masses.

Yet Hayes Newington's prognosis proved unduly pessimistic. Four months after his admission Marshall

was transferred to single care with a Dr Hall in Brighton, and one month after that he was released from certificates. Although I have been unable to find any evidence of Marshall's career after he gave evidence to the select committee in the following June, up until that time he had been living at home, apparently well.²⁷⁵

Like James Brook, Walter Marshall came from a prosperous Leeds textile family, and the Newingtons may have hoped he would become a similarly long-stay, untroublesome, top fee paying patient. Their reluctance to let Marshall go is evident in the fact that, when two doctors sent by Marshall's brother examined Walter in September 1876 and declared him well enough to go out on trial, 'Dr Newington' cautioned that they had seen Walter at his best. It was in view of this that the commissioners recommended that, rather than be released on trial, Walter should be transferred to single care.²⁷⁶ Fresh from his training under David Skae (1808-73) and Thomas Clouston (1840-1915) at Morningside Asylum in Edinburgh, Hayes Newington had a particular interest in cases of syphilitic insanity, and had written his first paper on one in 1873.²⁷⁷ In addition, syphilitic cases were amongst the most common at Morningside, and whilst this would have given Hayes Newington clinical experience of its symptomatology, it might also have led him to anticipate its presence.²⁷⁸ Certainly after Hayes

Newington's arrival at Ticehurst there was a cluster of diagnoses of 'general paralysis', and as he candidly admitted to the Medico-Psychological Association in 1900, at Ticehurst:²⁷⁹

We have had some mistakes in diagnosis. One case had all the usual symptoms [of general paralysis] well marked, left us relieved, has been cured elsewhere, and under various forms of control since, but after eleven years we believe he is as lively as ever.

The time-lag of eleven years is too short for this case-history to refer to Walter Marshall, but Hayes Newington's admission substantiates the likelihood that (despite the fact that every other doctor who examined Marshall concurred with the Newingtons' diagnosis) they may have also been mistaken in Walter Marshall's case.

However, none of the evidence presented to the select committee proved intentional malpractice on the part of the Newingtons, rather than errors of judgement. In addition, Samuel Newington had powerful allies, and was supported in his evidence not only by Charles Palmer Phillips, but by Lord Shaftesbury, who told the select committee that 'To abolish such a house as Ticehurst, for instance, would be a positive loss to science and humanity'.²⁸⁰ Even those ex-patients who felt that they had been taken advantage of by the Newingtons mostly spoke well of Ticehurst's standards of physical care and medical treatment. Thus John Perceval believed that 'had

he been placed at first under Mr C. Newington, he should within three or six months have recovered his understanding'; and John Thomas attributed his recovery at Ticehurst, after over twelve years of confinement elsewhere, to the full diet he was allowed there. Walter Marshall, who spent a few days at Munster House in Fulham before arriving in Sussex told the select committee that: '[At Ticehurst] I was very kindly treated, and it was a very pleasant change. I had much more liberty; I was able to walk about the country with an attendant, in place of being walked round the garden.'.²⁸¹ Only Herman Charles Merivale, who had no experience of treatment at another private asylum, wrote of Ticehurst in a uniformly critical way.

Since the 1877 select committee concluded without recommending the closure of private asylums, the L.L.R.A. continued to lobby parliament with their case. Although he was not a member of the Association, Merivale's book appeared in 1879, and contributed to the reformers' arsenal. In 1883 Louisa Lowe published a diatribe against private asylums, The Bastilles of England which took up the cases of Merivale, Preston and another former patient at Ticehurst, Sir Samuel Fludyer. It is unclear whether Louisa Lowe identified the asylum Merivale described as 'Pecksniff Hall' as Ticehurst - if she did, she does not say so - but in the other two cases she

documented Ticehurst was named. In both, the motive for confining the patients was seen as financial on the part of the patients' families and the Newingtons. The interests of Preston's brother were described above; Fludyer's father had left a will in which if Samuel died without an heir his money was to be transferred to other male relations on the father's side rather than his daughter's. Louisa Lowe accused the sisters of having Samuel certified after an argument, and writing a will in their own favour. Her information was inaccurate in so far as she claimed no lunacy commission had been held on Fludyer's case: one had been held in 1858, and found him insane. She was right however to suspect the Newingtons of having a high financial interest in Sir Samuel's confinement, since at a charge of twelve guineas a week he was the highest fee-paying patient at Ticehurst in the 1840s.²⁸²

Lowe's argument was considerably weakened by the fact that the cases she chose to consider from Ticehurst died some years before her book was published (Sir Samuel in 1876 and Preston in 1877); and because the select committee had concluded during Preston's lifetime that he was properly confined. However, in attacking Ticehurst, lunacy reformers like Louisa Lowe struck at the core of the system to which they were opposed. In the liberal climate of the early 1880s their case gained ground, and

won the support of prominent medical psychologists like John Charles Bucknill. In 1886 a bill proposing to end the issue of new licences for private asylums came before parliament, and the possibility of total abolition was raised. Some patients at Ticehurst were anxious about what closure would mean for them. In June 1886 the commissioners visiting Ticehurst observed that:²⁸³

The bill before parliament for amendment of the Lunacy Laws was on the lips of many, and one lady especially inveighed against the abolition of private asylums, in which she has herself (here & elsewhere) passed many years of her life.

Hayes Newington was sceptical whether the lunacy reform movement spoke for the majority of patients. At a meeting of the Medico-Psychological Association in July 1886 when abolition was discussed he argued that:²⁸⁴

it was quite a question whether that prejudice [against private asylums] was mainly on the part of those most concerned, viz., the patients. There was, of course, much prejudice on the part of the patients' friends, but, taking patients themselves, the acute maniac did not care where he was, the melancholiac would be miserable anywhere, and it was principally the 'moral insanity' cases which made the most noise from the patient's point of view, and they were just the people in asylums whose opinions should be considered the least.

Bluff as this was, it expressed a range of possible reactions to confinement which could not be given scope within the lunacy reform movement. The commissioners consistently reported most patients to be satisfied with their treatment at Ticehurst: 'not one complained of the

treatment he receives here', 'several of them spoke in the highest terms of the kindness shown them', 'more than one patient expressed their satisfaction at the treatment they received, and acknowledged how much they were indebted to it'.²⁸⁵ If it is easy to imagine that patients had good reason to appear rationally grateful for their treatment when the commissioners were visiting, this cannot explain those patients who wrote letters of thanks to the Newingtons after leaving Ticehurst, or for further advice on how best to maintain their regained mental equilibrium.²⁸⁶ It is important to set these voices against those of Walter Marshall and Herman Merivale, both of whom in addition to their personal experience of confinement had a political investment as active liberals in the campaign for lunacy reform.

The bill before parliament was thrown out at its second reading on 11 June 1886, and the subsequent defeat of the Gladstone administration meant that it was not re-introduced. The more moderate Lunacy Act which was passed in 1890 will be discussed in the next chapter. What it is worth bringing out here is the way in which the controversial public image of private asylums, and particularly allegations that some patients' relations had confined them for mercenary reasons, may have affected the feelings of families who were considering certification. The decision to confine a relative or

friend, even when it was believed that this was in the individual's best interests, could lead to strong feelings of guilt. Walter Marshall had been depressed for many years before he became a patient at Ticehurst in May 1876. Immediately prior to his admission he had become very excited campaigning for the Liberals during the elections. He spent money backing business deals which his family believed were bad investments. His wife Annie, other family and friends were concerned by his change of character.²⁸⁷

From the outset, Marshall believed that he had been unjustly confined. Following Gull's confirmatory diagnosis of G.P.I., Marshall's cousin, the psychical researcher Frederic Myers (1843-1901), wrote to his friend Henry Sidgwick (1838-1900): 'Gull has seen W. & expresses a very unfavourable opinion. [N]ewington tells me he thinks he will never leave Ticehurst. W. is now angry and complaining of plots etc. wh. much distresses A..'²⁸⁸ The situation was compounded by the fact that for several years Myers had been in love with Annie, and although they had agreed not to allow their relationship to become a sexual one, they were close friends. Both had felt that it would be morally wrong for them to become lovers, despite the fact that as atheists they could not justify their decision by reference to a Christian code of ethics or hopes for compensatory

happiness in a future life, and had already learned to brave social disapprobation. Myers later wrote exultantly of their decision:²⁸⁹

I had guessed not, did I not know, that
 the spirit of man was so strong
 To prefer irredeemable woe to the
 slightest shadow of wrong;
 I had guessed not, had I not known, that
 twain in their last emprise,
 Full-souled, and awake, and alone, with
 the whole world's love in their eyes,
 With no faith in God to appal them, no
 fear of man in their breast,
 With nothing but Honour to call them,
 could yet find Honour the best ...

but it is possible that Annie felt less reconciled to the loss entailed by such idealism.

Alan Gauld has rightly dismissed the suggestion of a genuine conspiracy between Frederic and Annie as unfounded; in fact they reacted to news of the putative seriousness of Walter's illness by deciding that it would be better if they stopped seeing each other. In August, Myers left for Norway, while Annie remained in the Lake District with her five children. On 19 August the Marshalls held a family conference at Keswick to discuss Walter's illness, and Annie asked to be relieved of the responsibility of taking decisions concerning his welfare. As Frederic's mother later wrote to her son, Annie's behaviour made the family concerned about her state of mind:²⁹⁰

She grew silent towards me, after having been quite frank and loving, & I could not with all my entreaties get her to speak of

what was in her mind, after she had once said that she saw she had been quite wrong in everything - in this last step for W. (the certif.) & altogether about religion - in rejecting Xianity - I hoped she wd. pass thro' this crisis.

But Annie's depression and anger deepened, and a few days later she committed suicide by drowning herself in Ullswater, after having failed in an attempt to cut her throat with a pair of scissors.²⁹¹

It seems likely that Annie's decision to have Walter certified was precipitous. Her fears for his sanity may have been coloured by her experience of having had two sisters who died insane, and her knowledge that one of Walter's brothers was incapable of managing his own affairs. Exhaustion from living with his intense activity and volubility, as well as his sleeplessness (he woke regularly at 5.00 a.m.) may have contributed to her decision.²⁹² Her subsequent suicide testifies to how fragile her own state of mind was. What is striking is the ease with which she was able to find doctors to certify him, despite the fact that although Walter had some physical symptoms indicative of a nervous disorder, he was neither delusional, nor dangerous to himself or others. The certificates emphasised reports by his relatives of his recent change of character, and of his recklessness with money.²⁹³ As asylum doctors, the Newingtons had to balance the social needs of their clients (primarily patients' families) against the

requirements of the law. Once a patient had been admitted, the continuing trust and confidence of the family depended on the ability of the Newingtons to negotiate the difficult feelings aroused by the patient's mental distress, and the decision to resort to certification. In many cases, describing mental disturbance in terms of individual organic pathology alleviated families' feelings of responsibility, although in Walter Marshall's case the Newingtons' pessimistic prognosis, and Walter's hostility to confinement, created additional and ultimately unbearable strain for Annie.

As the previous section of this chapter described, from the mid-1860s gynaecology offered a more orthodox medical alternative than homeopathy and hydropathy for the physical attribution and treatment of mental disorders in female patients. Thus before the Countess of Durham was certified in 1885 she had been taken on holiday to Cannes with her sister-in-law, and to consult the eminent gynaecologist Matthews Duncan, before consulting a psychological physician, George Fielding Blandford (who was, incidentally, a frequent certifier of admissions to Ticehurst). In this case too, an examination by Sir William Gull had directed the course of treatment, when he advised the Countess of Durham's family that her malady was physical rather than mental in origin. Medical evidence given in camera during her husband's

suit for divorce apparently centred on a debate over whether the Countess had been imbecile from childhood (in which case the marriage would have been null and void), or whether her case was one of 'post-connubial insanity'. Unlike one Times editorial on the case, editorials in the British Medical Journal and the Lancet did not speculate on whether, if it were a case of 'post-connubial insanity', the Duke's behaviour could have precipitated his wife's breakdown.²⁹⁵

The 'supposed causes' of insanity listed in the admission notes at Ticehurst rarely pointed to family relationships as a source of stress. Rather, they attributed mental disturbance to accidents ('blow on the head', 'a fall'), physical ill-health ('influenza', 'fever'), natural processes ('childbirth', 'her age'), or the environment ('tropical climate', 'long residence in India'). Or it was attributed to the individual's role in society ('excitement from business', 'overwork in the ministry'), an adverse change of circumstances ('loss of property', 'business failure'), or the individual's lack of moderation and self-control ('intemperance', 'irregular living', 'self-abuse'). Where mental disturbance was seen as resulting from the family, the stress referred to was generally beyond the family's control ('bereavement', 'sudden illness of adopted daughter'). The only other emotional circumstance seen as commonly affecting mental

stability was rejection in love ('disappointed affections', 'disappointment in love'). The one patient whose breakdown was attributed to an 'unhappy marriage' was referred by her mother rather than her husband. As mentioned in the previous section, 'heredity' was only very rarely given as the supposed cause.²⁹⁶

From within the asylum, the Newingtons protected the family from the patient's bizarre or extreme behaviour. As well as removing patients from their home environments the Newingtons regulated the degree of contact patients were allowed to have with the outside world, for example censoring patients' letters.²⁹⁷ As Nancy Tomes has argued:²⁹⁸

Hospitalization justified the removal of a disruptive individual while at the same time promising medical treatment and a possible cure. Hospital treatment thus addressed the powerful sense of guilt and helplessness expressed by so many families when dealing with an insane relative.

Yet as noted above, real confidence in the capabilities of the medical profession was limited; as was the Newingtons' actual ability to 'cure'. When the patient population is taken in profile at any one time, the prognosis most patients and their relatives or friends could look forward to appears bleak. The median length of stay for patients resident in Ticehurst at any one time fluctuated around twenty-five years (see Table 33). Between 60 and 80 per cent of those resident could expect

to die in Ticehurst, and only between 2 and 11 per cent could expect to be discharged 'recovered' (see Figure 9). Statistics like these have led Andrew Scull to conclude that:²⁹⁹

the rich could buy greater attention and more eminent psychiatrists for their crazy relatives, but not more cures; so that for all the lavish expenditure of funds, private asylums remained in Bucknill's words "institutions for private imprisonment".

Looking instead at the outcome for patients grouped by date of admission, this picture is inverted. As Laurence Ray found for the county asylums at Brookwood and Lancaster, and Anne Digby noted at the Retreat, the median length of stay for patients admitted to Ticehurst between 1 August 1845 and 31 July 1885 was around one year.³⁰⁰ At Ticehurst the median length of stay for first admissions between 1 August 1875 and 31 July 1885 declined to one third what the median length of stay had been for first admissions between 1 August 1845 and 31 July 1855 (see Table 32). Between 60 and 80 per cent of those admitted could expect to be discharged, although only between 16 and 39 per cent were actually 'recovered' (see Figure 11). Whilst this rate of recovery modifies Andrew Scull's assessment of the rate of 'cure' as 'abysmally low', more importantly the discharge of almost half of all admissions when they were not improved or recovered undermines the image of private asylums (like

public ones) as dumping grounds for social misfits.

Certainly Scull is right to argue that money could not buy health: Ticehurst's recovery rate was less good than, for example, the Retreat's. Only just over one quarter of first admissions to Ticehurst between 1845 and 1885 were discharged 'recovered', although clearly there must have been an element of subjective judgement by doctors in deciding whether to list a patient as 'recovered' rather than 'relieved', or 'relieved' (albeit slightly) rather than 'not improved'.³⁰¹ But given the therapeutic resources available to mid-Victorian psychological physicians, the criterion of 'cure' seems an unrealistic one by which to assess the success or failure of any individual institution, despite the fact that it formed part of the reformers', and the medical profession's, own rhetoric in calling for asylums to be built, and to be staffed by medical men. From the perspective of a medical philosophy which was non-heroic and placed great reliance on working harmoniously with nature, the more individual attention to patients at Ticehurst would have been perceived as making a real difference; and from the point of view of the patients' quality of life it almost certainly did. Two years after Lord Shaftesbury had described Ticehurst as a benefit 'to science and humanity', Merivale noted that at the time of his admissions (in 1875-6) Ticehurst had been regarded as an

asylum which was 'chiefly for 'incurables''.³⁰² To the Evangelical earl, despite his syntax, 'humanity' was clearly of more than equal importance to 'science'. Furthermore, the growth of a more deterministic, Darwinist psychiatry in the 1860s and 1870s provided new rationales for the failure of Victorian asylums to fulfill the reformers' hopes of increased recoveries, even though it jarred with earlier, more optimistic, conceptions of nature.

No doubt many patients and their families initially approached the Newingtons hoping for a cure, even if they had been given pessimistic prognoses elsewhere. As has been argued throughout this section, for many consulting a psychological physician came at the end of a pragmatic search for help from homeopaths, hydropathists and gynaecologists; or after attempts at self-help through holidays abroad and increased rest and relaxation. Yet as was clear in Walter Marshall's case, the Newingtons felt little reservation in telling a patient's family when they believed there was no hope of recovery, suggesting that the ability to cure was not of primary importance to their role as private asylum physicians. In the case of James Brook, Samuel Newington consoled Dearman Birchall three years after Brook's certification that, although the case was incurable, 'Jimmy past abusing himself is taking large doses of Bromide of

potassium and may live a good age'; and Birchall at least became reconciled to the incurability of Brook's complaint.³⁰³ Given the limitations of mid-Victorian psychiatric therapeutics, it would be wrong to underestimate the importance to a patient's family that in the absence of a cure their relative would be well fed, tenderly nursed, and regularly entertained in a luxurious and tranquil environment. The genteel ethos maintained at Ticehurst reassured the families of prospective patients that they could continue to enjoy many of the benefits of their privileged social position despite their illness.

Social embarrassment was one reason why patients like Brook were confined; yet it is hard to imagine that those patients who were suffering from chronic, particularly neurological, disorders could have led improved lives elsewhere. The Newingtons' experience, and attention to the details of nursing and nourishment meant that, for example, their general paralytics enjoyed a longer than average life-expectancy.³⁰⁴ Henrietta Unwin's case, and the findings of the select committee of 1877, suggest that many of the A.L.F.S.'s and L.L.R.A.'s fears about wrongful confinement in asylums were unfounded, although some people may have been confined in unreported single care because of family disagreements. The reluctance of many families to discard their relatives permanently

because of the embarrassment and distress they caused was reflected in the high discharge rate of patients who were 'not improved' or only 'relieved' to continue their search for health elsewhere, or to live at home; although clearly, and understandably, the Newingtons were cautious in their willingness to endorse such changes.

However, the Ticehurst case notes do show how often individual patients' disturbances were part of a wider pattern of family problems. Removing a patient from home eased family tensions, and it was partly this social need which asylums like Ticehurst successfully fulfilled. The rate of discharge of patients who were not recovered or relieved also suggests that often temporary removal was sufficient. Laurence Ray is right to argue that there was a more fluid interchange between the Victorian asylum and the outside world than is suggested by Scull's emphasis on the accumulation of chronic cases. What remains to be explored in the next chapter is how far advances in other areas of medicine, such as the development of anaesthesia, antisepsis and the bacteriological discoveries of the 1870s and 1880s unsettled public resignation to the extensive incurability of mental disorders; and how doctors like Hayes Newington sought to extend the increasingly scientific image of medicine to the psychological arena, despite an absence of significant therapeutic change.

NOTES: CHAPTER 3

1. Act for the Regulation of the Care and Treatment of Lunatics, 8 & 9 Vict., c.100.
2. Application for licence for Ticehurst House, 1842 (QAL/1/2/E2).
3. ibid., 1844; Visitors' Books, 1833-45, entry for 16 January 1836; and 1845-69, entry for 21 December 1846.
Thomas Thomson, M.D. Paris (1816); L.R.C.P., London (1817); F.R.C.P. (1843). (See Munk's Roll).
John Bramston Wilmot, son of Robert Montagu Wilmot (see Chapter I, note 78). M.B. Cantab (1828); M.D. Cantab (1834); F.R.C.P., London (1835). Tunbridge Wells physician. (See Munk's Roll).
4. Medical Journal and Weekly Report, 1845-53.
5. Second Lunacy Commissioners' Report, (PP1847-8(34.)XXVI.225-), pp.5-6; H.F.H.Newington and A.S.L.Newington, 'Some Incidents in the History and Practice of Ticehurst Asylum', Journal of Mental Science, 47 (1901), p.63; William Ll. Parry-Jones, The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries (London: Routledge & Kegan Paul, 1972), p.37.
6. Nicholas Hervey, 'A Slavish Bowing Down: The Lunacy Commissioners and the Psychiatric Profession, 1845-60', in W.F.Bynum, Roy Porter and Michael Shepherd (eds), The Anatomy of Madness. Essays in the History of Psychiatry. Vol. II: Institutions and Society, (London: Tavistock Publications, 1985), p.116; I am grateful to Nicholas Hervey for the information concerning Jesse Henry Newington.
7. Patients' Book, 1846-1904, entry for 31 July 1850; Case Book 1, passim.
8. Nicholas Hervey, op.cit. note 6, p.114.
9. ibid., pp. 105-6 & 114-5.
10. For example, notes on Dr Blagden (admitted 1817), Mary Morris (admitted 1818), Mary Stoneham (admitted 1822), Elizabeth Phipps (admitted 1823) and Sir Walter Yea (admitted 1825), Case Book 1, pp. opposite 22, 37, opposite 41, opposite 59 & 70. For the commencement of notes by Charles Hayes Newington, see for example p. opposite 12.

11. Visitors' Book, 1845-69, entries for 28 June and 8 July 1852; The Times, 23 April 1852, p.7; M.A.Lower, The Worthies of Sussex: Biographical Sketches of the Most Eminent Inhabitants of the County, from the Earliest Period to the Present Time (Lewes: printed for subscribers only by G.P.Bacon, 1865), p.255.
12. There was no obituary in the Lancet, 1 (1852); nor the Provincial Medical and Surgical Journal, (1852). See Gentleman's Magazine, (1852), p.107.
13. Visitors' Book, 1845-69, entries for 28 June and 8 July 1852.
14. William Ll. Parry-Jones, op.cit. note 5, p.90
15. Nicholas Hervey, op.cit. note 6, p.113.
16. ibid., p.127 footnote 127; and Registry of Admissions, 1845-81, case no. 67.
17. ibid., case nos. 11, 13, 77, 79, 83, 84, 97, 107, 131, 134, 139, 148, 275 & 325.
18. Admissions certificate for William Raikes 25 February 1851 (QAL/1/4/E6).
19. ibid., for example certificates for Lady Beatrix Legge, 15 December 1853, 'previously under Dr Forbes Winslow & William Duke, St Leonards'; and Henry Shepherd, 18 August 1855, who had been 'since 1841 with Mr Mayer at Highgate, Mr Helling at Clifford, Mr Duft at St John's Wood and Seymour St, and Mr Edwards at Brompton and Richmond'.
20. G.M.Burrows (Clapham Retreat), G.W.Daniell (Southall Park), H.W.Diamond (Twickenham House), E.T.Monro (Brooke House) and W.Wood (Kensington House and later the Priory, Roehampton) all certified admissions to Ticehurst. In addition, other patients not certified by these practitioners were referred from asylums run by these doctors and others in Morison's Society: Bailbrook House (run by J.B.Daniel), Brooke House, Clapham Retreat, Kensington House and Southall Park. (See Registry of Admissions, 1845-81, case nos. 50, 54, 62, 63, 93, 108, 118, 190, 211, 219, 223, 260, 330, 349, 350, 354, 376, 386, 394, 403, 433, 435, 498 and 517).
21. ibid., case nos. 13, 46 & 97.
22. Alumni Cantab. entries on Robert Nairne and Charles Hayes Newington. It was possibly through Charles

Hayes' training at St George's that Robert Keate, a surgeon at St George's, heard of Ticehurst and sent his wife there in 1842 (see Chapter 2, note 182).

23. Leonard J. Hodson & Julia Odell, Ticehurst: The Story of a Sussex Parish, (Tunbridge Wells: "Courier" Co., 1925), pp.43-4 & 58.
24. Obituary of Samuel Newington, The Gardeners' Chronicle, 15 July 1882, p.90; [Samuel Newington] 'Sigma', Progress in Agriculture, with a Description of the "Mulum in Parvo" and Important Implements, (London: James Ridgeway, 1858), p.20.
25. ibid.; and idem., Thick and Thin Seeding, or a New and Scientific Method of Seeding Grain. To which is Added a Description of a Certain Remedy for Hop Blight and All Plant Vermin, (London: James Ridgeway 1856); idem., The Corn Planter, (London: James Ridgeway, 1857); idem., The New Method of Planting, Setting, or Dibbling Grain, Pulse, Marigold etc.; with a Description of an Invention to Carry Out the System in an Expeditious, Economical and Perfect Manner; also a Description of the Light Drag Hoe and Hand Cultivator, to Hoe and Stir between Crops Growing in Rows. An Appendix on the Aphis, Hop or Green-Fly, and How to Totally Destroy the Same, (London: James Ridgeway, 1857); idem., The Corn, Bean and Marigold Planter, (London: James Ridgeway, 1858).
26. idem., The Corn Planter, (1857), p.28.
27. idem., op.cit. note 24, p.20.
28. ibid., loc.cit..
29. Visitors' Book, 1869-87, entry for 25 June 1879. I am grateful to Nicholas Hervey for directing me to the Forster correspondence at the Victoria and Albert Museum. Letter from Bryan Proctor to John Forster, September 1864:
 Lutwidge and Nairne [who were both lunacy commissioners] each received a box of magnificent grapes and pears from Ticehurst yesterday.
 (V.& A./48 E32).
30. Lancet, 1 (1863), p.80; British Medical Journal, 1 (1863), p.76.
31. Samuel Newington, 'On a New Remedial Agent in the Treatment of Insanity', Lancet, 1 (1865), p.621; and Journal of Mental Science, 10 (1865), pp.272-5.

32. Ironically, the agricultural course which Edis had taken at Cirencester was one which John Charles Bucknill (1817-97) cited as a satirical example of the kind of qualification the lunacy commissioners would admire in an asylum superintendent, because of their high evaluation of the therapeutic potential of farm-work (see Nicholas Hervey, op.cit. note 6, p.124 footnote 87).
Arthur Wellesley Edis (1840-93) b. Huntingdonshire. Educated at grammar school, before taking a course in agriculture and veterinary surgery at Cirencester. Studied medicine at the Westminster Hospital, MRCS Eng. (1862), MB London (1863). Assistant Medical Officer at Ticehurst, 1864-6. MRCP (1867) and MD London (1868). Studied in Vienna and Paris as well as London, and did ambulance work during the Paris Commune. Physician accoucheur St George's and St James' Dispensary, 1868-9. Fellow Obstetrical Society. Assistant Physician Hospital for Women, Soho, 1870-4; Physician British Lying-In Hospital, and to Dressmakers' Providential and Benevolent Institution. In 1874 he became Assistant Obstetrical Physician at the Middlesex Hospital, and one year later opened a Wimpole Street practice. Eventually became a full physician at the Middlesex Hospital, and lecturer on the diseases of women. Resigned from the Middlesex Hospital practice in 1889 because of pressure from his private practice, but continued to do hospital work at the Chelsea Hospital. President of the British Gynaecological Society, 1889. Married a sister of Dr John Murray (1844-73), who was sub-editor of the British Medical Journal. Edis published many gynaecological articles in the British Medical Journal, Lancet, Medical Times and Gazette, Obstetrical Journal and Obstetrical Transactions, as well as: Counter Seats for Shopwomen. The Standing Evil, (London: 1878); introduction to Children: their Health, Training and Education (London: 1879); Diseases of Women, Including their Pathology, Causation, Symptoms, Diagnosis and Treatment, (London: Smith, Elder & Co., 1881); Sterility in Women: Including its Causation and Treatment, (London: H.K.Lewis, 1890). (Medical Directory and Munk's Roll).
33. For Belgrave's appointment see Visitors' Book 1845-69, entry for 7 May 1866; Belgrave's article was 'On the Use of the Bromides of Potassium, Ammonium and Cadmium in the Treatment of Epileptic and Other Forms of Mania', Journal of Mental Science, 11 (1866), pp.363-71.

Thomas Bowerman Belgrave

MRCS Eng. and LSA (1858), King's College London. MD (1864), for a thesis on hemiplegia, Edinburgh. Resident Assistant Medical Officer, Lincoln County Asylum, Bracebridge, 1865-6. Assistant Medical Officer at Ticehurst, 1866-7. Resident Physician, Munster House, Fulham, 1867-8. Member of the Medico-Psychological Association, honorary member King's College Medical Society, fellow of the Obstetrical Society of Edinburgh. Physician, House of Mercy, Hendon, 1868-9. Physician and lecturer on medicine, St Joseph's Mission College, Mill Hill; District Medical Officer Southern Division Police, 1869-75. Emigrated to Australia in 1875, disappeared from Medical Directory, 1911. Apart from the article on bromides, Belgrave published: 'On Pirogoff's Operation', Transactions of King's College Medical Society, (1859); 'On the Asylums of St Petersburg and Copenhagen' Journal of Mental Science, 13 (1867), pp.7-19; 'On the Treatment of Cholera in Russia during the Epidemic of 1856' Medical Times and Gazette, (1870); 'The Carica Papaya as a Galactagogue' Transactions of the Royal Society of New South Wales, (1884). (Medical Directory).

34. Wolstan Fleetwood Dixie

MRCS Eng (1855), LSA (1857), St George's. MD St Andrew's (1857). Practised in Leamington Spa before becoming 'resident physician' at Ticehurst, 1868-9. Dixie was listed as of unknown address in the Medical Directory from 1870, and in the Medical Register simply as resident in London, with no precise address. The Medical Register for 1880 gave Dixie's address as 'The Pacific Steam Navigation Company', suggesting that he may have been employed as a ship's doctor.

John Alexander Easton

LRCS Edinburgh (1862), MD Glasgow (1862). House Surgeon Royal Infirmary, Glasgow. Assistant physician at Ticehurst, 1869-71. Then moved to Petworth in Sussex. (Medical Directory).

Francis Wilton

MRCS Eng (1855), LM (1856), St Bartholomew's Hospital. Assistant Medical Officer, Gloucester County Lunatic Asylum, 1856-65; Medical Superintendent Joint Counties Asylum, Carmarthen 1866-9. Member Medico-Psychological Association. At Ticehurst 1871-82. (*ibid.*). Published 'A Case of Obstinate Constipation and Inactivity of the Liver', Journal of Mental Science, 26 (1880-1), pp.67-9.

35. Visitors' Books, 1845-69, entry for 29 April 1863;

1869-87, entries for 26 April 1870, 27 October 1871, 17 June 1872 and 23 March 1874.

36. Ticehurst Asylum audits, 1869 and 1870.
37. Leonard Hodson and Julia Odell, op.cit. note 23, pp.38-9; Visitors' Books, 1845-69, entry for 18 June 1864; and 1869-87, entries for 23 March 1874 and 7 December 1877; and Ticehurst Asylum audits, 1870 and 1880.
38. Censuses for 1861 and 1871 (RG9.570 and RG10.1046).
39. Medical Directory.
40. ibid.; Alexander Samuel Lysaught, Walter James, Campbell, Theodore and Adrian Hayes Newington went to Cambridge (see Newington Family Trees IV and V, and Alumni Cantab.).
41. Ticehurst Asylum audit, 1880.
42. Registry of Admissions, 1845-81, cases 1-58 (House) and 1-6 (Highlands).
43. ibid., loc.cit..
44. Bill Book, 1840-6, passim and especially pp.18, 44 & 87.
45. Registry of Admissions, 1845-81, case nos. 1-17 and 1 (Highlands), especially case nos. 1-5 and 15-16 (House).
46. Bill Book, 1840-6, pp.43 & 44; Register of Discharges and Deaths, 1845-90, entries for 12 December 1879 and 12 March 1881.
47. ibid., entry for 11 April 1861.
48. Registry of Admissions, 1845-81, case nos.45, 53 and 57.

49.	Total in U.K. *		<u>Private Patients</u>		County and Borough Asylums	
			<u>Provincial Licensed Houses</u>			
	Men	Women	Men	Women	Men	Women
1850	1,906	1,868	800	757	120	112
1860	2,696	2,231	874	732	121	106
1870	2,813	2,559	771	707	130	129 ⁱ
1880	3,391	3,203	745	809	211	273
1890	2,728	3,313	560	771	501	526
1900	2,870	3,961	532	781	707	901
* not including naval, military and single patients.						

or idiots;

i in 1869 there were 107 male and 118 female private patients in county and borough asylums, and after 1870 consistently more women than men who were private patients in these asylums.

Sources: Lunacy Commissioners' Reports, 1850, p.25; 1860, p.117; 1870, pp.96-7; 1880, p.155; 1890, p.135 and 1900, p.193.

The number of patients in single care began to be listed in the lunacy commissioners' reports in 1865, and consistently showed women to outnumber men amongst those cases known to the lunacy commissioners:

	<u>Single Patients</u>	
	Men	Women
1865	89	123
1875	172	269
1885	189	256

Sources: Lunacy Commissioners' Reports, 1865, p.29; 1875, p.51 and 1885, p.111.

50. Anne Digby, Madness, Morality and Medicine. A Study of the York Retreat, 1796-1914, (Cambridge and New York: Cambridge University Press, 1985), p.176.
51. Registry of Admissions, 1845-81, for example case nos. 101, 236 and 392. Other examples of patients who had been on journeys abroad before being certified were Herman Charles Merivale and the Countess of Durham (see below).
52. Letters Book 1857-73, entries for 23 January and 7 August 1863.
53. Registry of Admissions 1845-81, case nos. 53, 210 and 241.
54. David Verey (ed.) The Diary of a Victorian Squire. Extracts from the Diaries and Letters of Dearman & Emily Birchall, (Gloucester: Alan Sutton, 1983), p.187. The medical superintendent at Barnwood, Dr Needham, had formerly been medical superintendent of the York Asylum (see Anne Digby, From York Lunatic Asylum to Bootham Park Hospital, Borthwick Papers no.69, (York: University of York, 1986), pp.34-41).
55. Registry of Admissions, 1845-81, case nos. 67, 153, 205, 537 and 590.
56. Statistical Appendix to the Report of the Metropolitan Commissioners in Lunacy to the Lord

Chancellor; Containing Tabular Returns from the Several Lunatic Asylums in England and Wales; also from Scotland and Ireland, (PP1844(621.)XVIII), p.178.

57. ibid., p.115; and Medical Directory (1873).
58. Seventh Lunacy Commissioners' Report, (PP1852-3 XLIX,1-), p.41.
59. John Charles Bucknill, 'Annual Reports of Lunatic Asylums', Journal of Mental Science 5 (1859), p.172.
60. ibid., loc.cit..
61. Nicholas Hervey, op.cit. note 6, p.112.
62. Medical Directory (1870).
63. ibid., and (1880)
64. op.cit. note 56, p.138; and Ninth Lunacy Commissioners' Report, (PP1854-5 XVII.535-), pp.19-20.
65. Charles Lockhart Robertson, 'A Descriptive Notice of the Sussex Lunatic Asylum, Haywards Heath (opened 25th July, 1859)', Journal of Mental Science, 6 (1860), pp.257 & 264.
66. Medical Directory, (1866-84) & (1890).
67. Registry of Admissions, 1845-81 case nos. 287, 303 and 537.
68. The commissioners had insisted that the number of patients at Ringmer should be reduced to three, but the subsequent death of the proprietor meant the asylum in fact closed. Ninth Lunacy Commissioners' Report, (PP1854-5 XVII.535-), pp.19-20; William Ll. Parry-Jones, op.cit. note 5, p.180.
69. Register of Discharges and Deaths, 1845-90.
70. See note 44; and Patients' Bill Books, 1870-5, passim and 1882-5, for example p.75.
71. J.A.Banks , Prosperity and Parenthood. A Study of Family Planning Among the Victorian Middle Classes, (London: Routledge & Kegan Paul, 1954), pp.185-6 and 188.
72. ibid., p.95; Patricia Branca's Silent Sisterhood. Middle-Class Women in the Victorian Home, (London:

- Croom Helm, 1975), pp. 27 & 65 suggests that a family living on £150 p.a. in 1874 might spend £5-£10 p.a. on doctors' bills, but this income is far lower than the minimum needed to send a patient to Ticehurst in the 1870s.
73. J.A.Banks, op.cit. note 71, p.110.
 74. Letters Book, 1857-73, for example entries for 26 July 1860, 14 September 1869, 13 July 1872 and December 1873.
 75. Revd James Maxwell, rector of Thorpe Bishop, Norwich 1813-57; patient at Ticehurst, 1843-57. Revd Joseph Dunnington Jefferson, vicar of Thorganby, Yorkshire, 1832-80; patient at Ticehurst, 1869-80. Revd Henry William Sullivan, rector of Yoxall, Staffordshire, 1851-80; patient at Ticehurst 1870-3 and 1874-80.
 76. cf. Asa Briggs, 'The Language of 'Class' in Early Nineteenth-Century England' in Asa Briggs and John Saville (eds), Essays in Labour History (London: Macmillan, 1967), p.43.
 77. Twenty-Ninth Lunacy Commissioners' Report, (PP1875 XXXIII.1-), p.93.
 78. Samuel Fludyer also paid over £1,000 by 1863. (Bill Book, 1846-54, p.62; Patients' Bill Book, 1876-81, pp.83 & 485).
 79. ibid., 1870-5, p.290.
 80. David Verey, op.cit. note 54, p. 75.
 81. ibid., p.77.
 82. Patients' Bill Books, 1876-71, p.24.
 83. W.R.Greg, 'Life at High Pressure', The Contemporary Review, 25 (1875), p.633.
 84. Visitors' Book, 1869-87, entry for 25 June 1879.
 85. ibid., loc.cit..
 86. David Verey, op.cit. note 54, p.121.
 87. Visitors' Books, 1845-69, entry for 20 November 1860; and 1869-87, entry for 7 December 1877.
 88. Registry of Admissions, 1845-81; Register of

Discharges and Deaths, 1845-90.

89. ibid.; and Register of Removals, Discharges and Deaths, 1890-1907; Register of Discharges and Transfers, 1907-30 and Register of Deaths, 1907-30.
90. Registry of Admissions, 1845-81, case nos. 1-58.
91. ibid., case nos. 59-91.
92. op.cit. note 56, pp.3 & 140.
93. Certificate of admission of Charlotte Muggeridge, 29 May 1846 reads '... there appears to be a deficiency of intellect, she often laughs without being able to assign any cause for so doing, & the mind seems to be under the influence of supernatural agency.' (QAL/1/4/E6). John Perceval, A Narrative of the Treatment Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity, (London: Effingham Wilson, 1840), p.317.
94. Registry of Admissions, 1845-81, case no. 82ff..
95. Case Book 1, for example, pp. 18 & 28.
96. ibid., p. opposite 23.
97. ibid., for example pp.2, opposite 15, opposite 19, opposite 25, 26, opposite 30, opposite 63(b), 72 & 83. Steven Jacyna, 'Scientific Naturalism in Victorian Britain: an Essay in the Social History of Ideas', (Edinburgh University Phd, 1980), p.184.
98. Case Book 1, p. opposite 63(b).
99. ibid., pp. opposite 19, 47 & 72.
100. ibid., p.6.
101. John Harley Warner, 'Therapeutic Explanation and the Edinburgh Bloodletting Controversy: Two Perspectives on the Medical Meaning of Science in the Mid-Nineteenth Century' Medical History, 24 (1980), pp.241-58, especially pp.246-7.
102. Case Book 1, p. opposite 30.
103. ibid., p. 34 & 42.

104. Case Book 1, p. 24.
105. Medical Journal and Weekly Report, 1845-53, entries for 6 October 1845 - 20 April 1852, especially 20 May 1850.
106. Dictionary of National Biography, entries on Charles and Elizabeth Mayo.
107. Charles and Elizabeth Mayo, Practical Remarks on Infant Education, (London: 1837), pp.3-6.
108. Dictionary of National Biography, entry on Charles Mayo.
109. Case Book 1, pp. 24 - opposite 25.
110. ibid., p.38.
111. Anne Digby, op.cit. note 50, p.134.
112. Case Book 1, pp. 1 & 28.
113. ibid., pp.5, 6, opposite 13, opposite 28, 68 & 83; Visitors' Books, 1833-45, entry for 30 August 1844, and 1845-69, entries for 8 July 1850 and 8 January 1851.
114. Case Book 1, pp. 12, opposite 13, 65, 68
115. ibid., pp.4 - opposite 5.
116. ibid., p.8.
117. ibid., p.71.
118. ibid., p.12.
119. ibid., loc.cit..
120. Medical Journal and Weekly Report, 1845-53, 17 February 1851 onwards; Medical Visitation Book, 1853-75, up to 11 May 1857. Charles Hayes and Samuel Newington commented on this increase in mechanical restraint in their reply to the lunacy commissioners' 1854 questionnaire (Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), pp.199-200. Case Book 1, pp.17 & opposite 34.
121. Case Book 2, pp.169-76.
122. Medical Journal and Weekly Report, 1845-53, entry for 20 January 1851; Medical Visitation Book, 1853-75, 27 November 1853 & 25 September 1854.

123. Samuel Tuke, Description of the Retreat. An Institution near York for Insane Persons of the Society of Friends. Containing an Account of its Origins and Progress, the Modes of Treatment, and a Statement of Cases, (York: W.Alexander, 1813), p.173.
124. Medical Visitation Book, 1853-75, 27 November 1853; and for example 25 February and 9 March 1858, 28 March 1864 and 6 March 1865. Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), p.200.
125. Case Book 2, pp. 112-4.
126. ibid., p.152 and Case Book 4, p.52; Medical Journal and Weekly Report, 1845-53, for example entry for 27 April 1852 and 31 January 1853. Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), p.200.
127. Case Book 2, pp.131 & 150.
128. Case Book 10, pp.139 & 143-2 (sic).
129. Case Book 2, p.114; Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), p.200.
130. Medical Journal and Weekly Report, 1845-53, entries for 29 June 1852 and 5 September 1853 onwards; first instance of mechanical restraint of a female patient to prevent masturbation was in Medical Visitation Book, 1853-75, entry for 19 August 1867.
131. As Peter Gay has noted, the Victorians' 'persistent panic over masturbation is far easier to document than to explain' (The Bourgeois Experience. Victoria to Freud. Vol. I, Education of the Senses, (Oxford: Oxford University Press, 1984), p.309). The following discuss Victorian attitudes to , and treatment of, masturbation: G.J.Barker-Benfield, The Horrors of the Half-Known Life: Male Attitudes Towards Women and Sexuality in Nineteenth-Century America (New York: Harper & Row, 1976), pp.124-31; John Duffy, 'Masturbation and Clitoridectomy: A Nineteenth-Century View' Journal of the American Medical Association 186 (1963), pp.246-8; H.T.Engelhardt, 'The Disease of Masturbation: Values and the Concept of Disease' Bulletin of the History of Medicine 48 (1974), pp.234-48; Ian Gibson, The English Vice. Beating, Sex and Shame in Victorian England and After (London: Duckworth, 1978) pp.31-2 & 136; A.N.Gilbert, 'Doctor, Patient and Onanist

- Diseases in the Nineteenth Century', Journal of the history of Medicine (July 1975), pp.217-34; John S. Haller and Robin Haller, The Physician and Sexuality in Victorian America, (Chicago and London: University of Illinois Press, 1974), especially chapter 5; E.H.Hare, 'Masturbatory Insanity: The History of an Idea', Journal of Mental Science 108 (1962), pp.1-25; Steven Marcus, The Other Victorians: A Study of Sexuality and Pornography in Mid-Nineteenth Century England, (London: Wiedenfeld and Nicolson, 1966), pp.19-22; Regina Morantz, 'The Lady and Her Physician' in Mary Hartmann and Lois W. Banner (eds) Clio's Consciousness Raised. New Perspectives on the History of Women (New York: Harper & Row, 1974), pp.38-53; R.P.Neuman, 'Masturbation, Madness and the Modern Concepts of Childhood and Adolescence', Journal of Social History (1975), pp.1-27; Elaine Showalter The Female Malady. Women, Madness and English Culture, 1830-1980 (New York: Pantheon Books, 1985), pp.75-8.
132. Medical Journal and Weekly Report, 1843-53, entry for 5 September 1853; Case Book 2, pp.123-4.
133. ibid., p.112.
134. For an assessment of Carpenter's influence on Victorian medical practice see Vance Hall, 'The Contribution of the Physiologist, William Benjamin Carpenter (1813-85), to the Development of the Principles of the Correlation of Forces and the Conservation of Energy' Medical History, 28 (1979), pp.134-5; William B.Carpenter, 'Article XVI: Insanity, Crime and Punishment', British and Foreign Medico-Chirurgical Review, 24 ii (1847), pp.225-42, especially pp.233-4. John Seed, 'Unitarianism, Political Economy and the Antimonies of Liberal Culture in Manchester, 1830-50', Social History, 7 (1982), pp.10-11.
135. William B.Carpenter, op.cit. note 134, p.240.
136. The connection between chronic masturbation and spermatorrhoea was widely popularized amongst medical men in England in the early 1840s, through discussion of Claude Francois Lallemand's Des Pertes Seminales Involontaires, 3 vols, (Paris: 1838-42). English translation appeared in 184 . Carpenter had originally emphasised that, although ejaculation was a reflex and sexual desire provided an instinctual motive for reproduction, sexual activity always had to be willed, and could be restrained (Principles of Human Physiology with their Chief Applications to Pathology, Hygiene and

Forensic Medicine, (London: J.Churchill, 1842).

However in October 1846 he argued that:

In certain disordered states of the nervous centres, the sexual sensations may be so highly excited, that they act directly upon the muscular system, not only without the aid of the intellect and will, but even in opposition to it, as is seen in the violent, semi-convulsive movements, excited in the nympho-maniacal patient by the sight of one of the opposite sex.

('Article XIII: Mr Noble on the Brain and its Physiology', British and Foreign Medico-Chirurgical Review, 22 ii, (1846), p.513).

The role of habit in establishing automatic movements was most clearly articulated by Carpenter in an article on R.B.Todd's Physiology of the Nervous System in the British and Foreign Medico-Chirurgical Review, 5 i, (1850), pp.1-50.

Roger Smith has discussed the use of pleas of automatism to explain violent actions in lunacy trials, Trial by Medicine. Insanity and Responsibility in Victorian Trials, (Edinburgh: Edinburgh University Press, 1981), pp.97-9.

137. William B.Carpenter, 'Review VIII: Carter on Hysteria', British and Foreign Medico-Chirurgical Review, 11 i, (1853), pp.425-6.
138. Case Book 2, pp.43-4 & 122-3.
139. Vance Hall, op.cit. note 134, pp.152-3; John Harley Warner, 'Physiological Theory and Therapeutic Explanation in the 1860s: The British Debate on the Medical Use of Alcohol' Bulletin of the History of Medicine, 54 (1980), pp.240-4.
140. Steven Jacyna, op.cit. note 97, pp.184-7; Andrew Scull, 'From Madness to Mental Illness: Medical Men as Moral Entrepreneurs', European Journal of Sociology, 16 (1975), pp.219-61; for galvanism, see for example the treatment of Charles Wise, Case Book 8, p.65.
141. ibid., 2, pp.122-3 & 176.
142. Emma Emerson was restrained with a sheet in September 1869; an attendant sat up with Jane Thompson in January 1868; alum was originally applied to women's genitals to treat leucorrhoea, for example in 1872 to Julia Brett, and in 1879 to Eliza Arkwright; and C.J. had his genitals coated with liquor epispasticus in 1895. (Case Books 13,

- p.145; 15, p.44; 16, p.135;24, p.231 and 36, p.15).
143. Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), pp.162-3, 164 & 167-9.
 144. ibid., p.200.
 145. ibid., loc.cit.
 146. ibid., loc.cit.; Patients' Book, 1846-1904, entry for 4 April 1879.
 147. Visitors' Book, 1869-87, entry for 25 June 1879.
 148. Tape of conversation with Herbert Francis Hayes Newington's grandson, Walter Newington.
 149. John Perceval, op.cit. note 93, p.143. Attendants' Book, loose letter inside front cover.
 150. [John Perceval], Narrative of the Treatment Experienced by a Gentleman During a State of Mental Derangement. Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity, (London: Effingham Wilson, 1838), pp.276-7 and op.cit. note 93, pp.xx-xxi. See also Nicholas Hervey, 'Advocacy or Folly: The Alleged Lunatics Friends Society, 1845-63', Medical History, 30 (1986), pp.251-2.
 151. Michael Clark, 'The Rejection of Psychological Approaches to Mental Disorder in the Late Nineteenth Century British Psychiatry', in Andrew Scull (ed) Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era, (London: Athlone Press, 1981), pp.292-300.
 152. Case Books 1, p. after 64, entry for 25 December 1850; 5, pp.116-22.
 153. ibid., 5, pp.111-2 & 114-5.
 154. ibid., 1, p.opposite 68; 4, p.118.
 155. Anne Digby, op.cit. note 50, p.38.
 156. Case Books 2, pp.47-8; 6, pp.78-9.
 157. ibid. 8, pp.134 & 136.
 158. Visitors' Book, 1846-69, entry for 24 October 1859.
 159. ibid., 1869-87, entry for 25 June 1879; [Herman

Charles Merivale], My Experiences in a Lunatic Asylum, by a Sane Patient, (London: Chatto and Windus, 1879), p.8.

160. Medical Visitation Book, 1853-75, entry for 7 June 1869; Twenty-Fourth Lunacy Commissioners' Report, (PP1870 XXXIV.1-), pp.45-6.
161. See note 34.
162. Anne Digby, op.cit. note 50, pp.55-6 & 85-6.
163. Klaus Doerner, Madmen and the Bourgeoisie. A Social History of Insanity and Psychiatry, (Oxford: Blackwell, 1981), pp.91-2.
164. Case Books 8, p.124 and 12, pp. 24 & 26.
165. Visitors' Book, 1869-87 23 March 1874; last reference to patients gardening was on 7 December 1877. H.F.H.Newington and A.S.L.Newington (op.cit. note 5, p.72) describe the failure of this venture. [Herman Charles Merivale], op.cit. note 159, p.73.
166. Case Books 1, p.87; Visitors' Books, 1845-69, entries for 19 December 1857, 29 April 1863, 18 June 1864, 14 July 1869; 1869-87, entries for 17 June 1872 and 27 July 1879. Moral control of certificates was described in ibid., entry for 23 January 1884; William Green's case was described in Case Book 16, p.48.
167. Visitors' Books 1845-69, entries for 8 July 1852, 15 October 1857, 18 June 1864, 11 December 1866; 1869-87, entries for 5 December 1870, 14 October 1878 and 29 May 1880. For Revd Cotton's lecture on Bees, see Daily Case Book, 1866-7, entry for 23 May 1867.
168. Eighth Lunacy Commissioners' Report, (PP1854 XXIX.1-), p.200.
169. Herman Charles Merivale, op.cit. note 159, p.73.
170. Case Books 1, p. after 10; 2, p.121.
171. ibid. 4, pp.110 & 139.
172. ibid. 14, p.10.
173. ibid. 9, p.51; Vance Hall, op.cit. note 134, p.152.
174. Case Books 4, p.40 & opposite 153.

175. ibid. 9, pp.16 & 76.
176. ibid. 11, p.78.
177. ibid. 3, p.33.
178. Visitors' Book 1845-69, entry for 1 December 1869.
179. ibid., entry for 16 October 1856.
180. It is clear from the Letters Book, 1857-73, that some of Anne Farquhar's family opposed her being placed in an asylum (see entry for 31 May 1858). Case Book 5, pp.1-5.
181. ibid., pp.5-6.
182. Case Books 4, p.59; 25, p.68. Patients' Book 1845-1904, entry for 26 May 1865.
183. Case Book 10, p.132.
184. ibid. 4, p.70.
185. ibid. 5, p.126 and 6, p.92.
186. Walter E. Houghton, The Victorian Frame of Mind, 1830-70, (New Haven and London: Yale University Press, 1957), p.264.
187. William B. Carpenter, op.cit. note 134, p.239.
188. Bruce Haley, The Healthy Body and Victorian Culture, (Cambridge and London: Harvard University Press, 1978), p.27.
189. Anne Digby, op.cit. note 50, pp.208-9.
190. Registry of Admissions, 1845-81, case nos. 9, 10, 11, 18, 21, 45, 53, 88, 91, 153, 161, 163, 164, 184, 193, 205 and 227. Of these, only Lord Henry Beauclerk's insanity was attributed to his heredity (ibid., case no.91).
191. William Rathbone Greg, 'On the Failure of Natural Selection in the Case of Man', Fraser's Magazine, 78 (1868), p.355.
192. For Lucy Greg's family, see W.V.Farrar, K.R.Farrar and E.L.Scott 'The Henrys of Manchester. Part 2. Thomas Henry's sons: Thomas, Peter and William', Ambix, 21 (1974), pp.188-207, especially p.191, footnote 49. After her own

recovery, Lucy Greg considered sending her sister Charlotte Henry to Ticehurst (Letters Book, 1857-73, entry for 20 August 1858).

193. Anne Digby, op.cit., note 50, p.212. Registry of Admissions, 1845-81, case no. 210.
194. Peter McCandless, ' 'Curses of Civilisation': Insanity and Drunkenness in Victorian Britain', British Journal of Addiction, 79 no.1 (1984), p.51.
195. See for example case of E.Greening, Registry of Admissions, 1845-81, case no.308; Case Book 18, p.97.
196. Lancet, 1 (1857), p.528.
197. David Verey, op.cit. note 54, pp.7 & 10.
198. See Roger Smith, Trial by Medicine. Insanity and Responsibility in Victorian Trials, (Edinburgh: Edinburgh University Press, 1981), chapter 7 for Victorian medico-psychological perceptions of women as particularly vulnerable to mental disorders during menstruation.
199. Bruce Haley, op.cit. note 188, chapter 2.
200. Admission certificates for Henrietta Unwin, April 1861 (QAL/1/4/E7); Registry of Admissions 1845-81, case nos. 188 and 210. 'General paralysis' was given as the mental disorder in case nos. 166, 197, 219 and 443. 'General Paralysis of the Insane' began to be used as a diagnosis in 1881, but its connection with syphilis was not understood, and supposed causes were variously given as 'drink & pecuniary difficulties', 'injury to head', 'business excitement', 'unknown' and 'not certain' (ibid., case nos. 469, 473, 495, 496, 513, 531 and 534).
201. Certificates for Anne Farquhar 2 July 1858 and Ann Hopkinson 30 October 1861 (QAL/1/4/E6 and E7).
202. Case Books 7, p.115 and 9, p. opposite 167.
203. ibid., 10, p. opposite 32.
204. Henrietta Unwin was placed on a diet of milk and farinaceous foods, although it is unclear whether this was intended to alleviate her mental condition, or because she was suffering from chronic diarrhoea (ibid. 11, p.103); Elaine Showalter discusses the use of fattening, low

protein, diets based on milk and cereals in the treatment of nymphomania; and the development of rest cures in the 1880s which included a milk-based diet (op.cit. note 131, p.129). For patients who were treated for debility see Medical Visitation Book, 1853-75, for example entries for February 1874.

205. John Harley Warner, op.cit., note 139, pp.250-3; Registry of Admissions, 1845-81, case nos. 172 and 203.
206. Case Book 10, pp.56 & 58.
207. ibid., 2, p. opposite 170; 9, p.78; 10, pp.30 & 146 and 11, p.6.
208. Case Books 4, pp.74-5 & 77; 10, pp.28-9.
209. ibid., 1, p.44; 3, pp.119-20.
210. ibid., 8, p.84; R.H.Balme, 'Early Medicinal Use of Bromides', Journal of the Royal College of Physicians, 10 (1976), pp.205-8.
211. Case Book 13, p.3.
212. Potassium iodide was also experimented with at the same time as potassium bromide, before bromism had been described (ibid., 8, p.136 & 10, p.121). One of Herbert Francis Newington's published papers described an epileptic patient at Ticehurst in the late 1870s who was subject to bromism, 'Case of an Extraordinary Number of Convulsions Occurring in an Epileptic Patient with Remarks on Nutrient Enemata', Journal of Mental Science, 23 (1877), pp.89-95; see also the case of Frances Bartram, Case Book 24, p.313.
213. Samuel Newington, Lancet article cited in note 31, p.621.
214. H.F.H. and A.S.L.Newington, op.cit. note 5, p.71; for the use of morphia and mustard baths to sedate and calm patients, see Case Books 15, p.62; 24, p.265; 25, pp.140 & 243 and 26, pp.129 & 143.
215. ibid., 2, p.146; 11, p.6; 13, p.3; 14, pp.4 & 72; 15, p.62.
216. See note 32.
217. Gynaecologists visited, for example, Eliza Arkwright and Frances Bartram (Case Books 24, p.266

- and 25, p.56). On ovarian and uterine 'irritation' see cases of Georgina Simpson and Henrietta Unwin (ibid., 11, pp.5 and 103).
218. ibid., 11, p.69; for example Frances Bartram was fitted with a pessary after Dr Edis visited her in 1879, ibid., 24, p.266.
 219. ibid., 21, p.25; [Herman Charles Merivale], op.cit. note 159, p.9. For placebos see Daily Case Book, 1866-7.
 220. Ticehurst Asylum audit, 1880; Anne Digby, op.cit. note 50, pp.125-6.
 221. Case Book 9, p.77.
 222. Bruce Haley, loc.cit. note 188.
 223. Nancy Tomes, A Generous Confidence. Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-83, (Cambridge and New York: Cambridge University Press, 1985), p.90.
 224. op.cit. note 56, p.141.
 225. John Perceval, op.cit. note 93, p.147; for Sussex in the cholera epidemic of 1831-2 see Michael Durey, The Return of the Plague. British Society and the Cholera, 1831-2 (London: Gill and Macmillan, 1979), p.32.
 226. William Ll. Parry-Jones, op.cit. note 5, pp.58-9.
 227. Susanna Winkworth, Letters and Memorials of Catherine Winkworth, 2 vols, (Clifton: for the author, 1883 & 1886), vol.I, p.67.
 228. Gordon N.Ray, The Letters and Private Papers of William Makepeace Thackeray, 4 vols, (London: Oxford University Press, 1945), II, p.81.
 229. Letters Book, 1857-73, entries for 31 May 1858 and ? January 1864.
 230. 19 were transferred to other private asylums, 7 into single care, 5 to registered hospitals and 1 to a county asylum (Register of Discharges and Deaths, 1845-90; Register of Removals, Discharges and Deaths, 1890-1907).
 231. Admission certificates for Washington Travers, (QAL/1/4/E6); Case Book 5, pp.9-11, 44, 71 & 80-1.

232. [Herman Charles Merivale], op.cit. note 159, p.84.
233. Terry M.Parssinen, 'Professional Deviants and the History of Medicine: Medical Mesmerists in Victorian Britain', in Roy Wallis (ed.), On the Margins of Science: the Social Construction of Rejected Knowledge, (Keele: Keele University Press, 1979), p.109.
234. Case Book 9, p.47.
235. See for example admission certificates for Dorothy Davis and Mary Hills (QAL/1/4/E6).
236. Samuel Greg, A Layman's Legacy, (London: Macmillan, 1877), pp.17, 21-3 & 33.
237. Case Book 5, pp.146-9.
238. Report from the Select Committee on Lunacy Laws; together with the Proceedings of the Committee, Minutes of Evidence, and Appendix, (PP1877 XIII.1-), p.75.
239. [Herman Charles Merivale], op.cit. note 159, pp.71-2.
240. John Perceval, op.cit. note 93, p.xi.
241. Susanna Winkworth, op.cit. note 227, vol. I, dedication and p.78.
242. J.A.V.Chapple and Arthur Pollard, The Letters of Mrs Gaskell (Manchester: Manchester University Press, 1966), p.225.
243. Susanna Winkworth, op.cit. note 227, vol. II, p.267; Henry Winkworth (d.15 May 1869), first codicil to his will, 23 May 1861.
244. Registry of Admissions, 1845-81, case no. 377.
245. Admissions certificates for Pauline Folliau, Charles Rawdon, Anna Direy, and Edward Lloyd (QAL/1/4/E6).
246. ibid., certificates for Revd Patterson and Elizabeth Winsor.
247. Case Book 4, p.48.
248. Admissions certificate for Arthur Basset (QAL/1/4/E6).

249. David Verey, op.cit. note 54, pp.3 & 5.
250. Susanna Winkworth, op.cit. note 227, vol.II, p.265.
251. Case Book 4, pp.71-2 and 74-5.
252. ibid., p.114.
253. Admissions certificate for Eliza Gipps (QAL/1/4/E6).
254. David Verey, op.cit. note 54, p.51.
255. Admissions certificates for Mary Turney, Frances Willington, Henry Shepherd and Isabella Foster (QAL/1/4/E6).
256. ibid., certificates for Henrietta Golding and Charles Mawley.
257. Local doctors who certified many admissions included Charles Adey from the East Sussex Infirmary in St Leonards (18); James Combs from Burwash (12); William Mercer, medical officer of the Wadhurst District of Ticehurst Union (45); John Taylor, medical officer of the Ticehurst Union (39); Charles Trustram, who practised in Tunbridge Wells (14); John Wardell, who also practised in Tunbridge Wells (9); and Francis Ayerst Young from Hawkhurst (31). (Registry of Admissions, 1845-81 and Register of Admissions, 1881-90).
258. Registry of Admissions, 1845-81, case no.199; Case Book 11, p.105.
259. See Report on the Operation of Acts of Parliament, and Regulations for the Care and Treatment of Lunatics and their Property, with Proceedings, Evidence, Appendix and Index, (PP1859(Sess.1)III.75-).
260. British Medical Journal (1858), p.561; see also Ralph Colp, jr., 'Charles Darwin, Dr Edward Lane, and the 'Singular Trial' of Robinson v. Robinson and Lane', Journal of the History of Medicine, 36 (1981), pp.205-13.
261. ibid., p.210-11; Case Book 11, p.103.
262. Peter McCandless, 'Liberty and Lunacy: the Victorians and Wrongful Confinement', in Andrew Scull (ed.) Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era, (London: Athlone Press, 1981), pp.355-7.

263. Letters Book, 1857-73, entry for 17 October, 1864.
264. Ticehurst Asylum audit, 1870.
265. [Herman Charles Merivale], op.cit. note 159, pp.44-6; John Perceval, op.cit. note 93, pp.95 & 268-9.
266. For a survey of the influence of Gheel lunatic colony on nineteenth-century asylum design, see William Ll. Parry-Jones, 'The Model of the Geel Lunatic Colony and Its Influence on the Nineteenth-Century Asylum System in Britain', in Andrew Scull (ed), Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era, (London: Athlone Press, 1981), pp.201-17. Nicholas Hervey, op.cit. note 150, pp.256 & 268.
267. Patients' Book, 1846-1904, entry for 16 October 1856.
268. ibid., entries for 6 February and 24 March 1873.
269. Nicholas Hervey, op.cit. note 150, p.264 discusses the case of Captain Childe, who was later a patient at Ticehurst.
270. David Verey, op.cit. note 54, pp.71-2; Louisa Lowe, The Bastilles of England; or, the Lunacy Laws at Work (London: Crookende, 1883), pp.20-5; op.cit. note 238, p.282.
271. ibid., pp.283, 365-8 & 440.
272. ibid., p.421.
273. Alan Gauld, The Founders of Psychical Research (London: Routledge and Kegan Paul, 1968), p.121.
274. Case Book 22, pp.96-8, 102 & 104.
275. Patients Book, 1846-1904, entry for 21 August 1876.
276. ibid., loc.cit.; and op.cit. note 238, p.422.
277. H.F.H.Newington, 'Notes on a Case of Insanity Dependent on Syphilis' Journal of Mental Science, (1874) 19, pp.555-60.
278. Margaret Sorbie Thompson, 'The Mad, the Bad and the Sad: Psychiatric Care at the Royal Edinburgh Asylum (Morningside), 1813-94', (Boston University PhD, 1984) p.208.

279. H.F.H.Newington and A.S.L.Newington, op.cit. note 5, p.68. See also H.F.H.Newington, 'Unverified Prognosis', Journal of Mental Science 30 (1884-5), pp.232-3 on a case which appeared to be one of G.P.I., but where the patient recovered.
280. op.cit. note 238, p.546.
281. Third person used in the original. John Perceval, op.cit. note 93, p.xiv. op.cit. note 238, p.421.
282. Louisa Lowe, op.cit. note 269, pp.20-3; Case Book 3, p.50; and Bill Book 1840-6, pp.18 & 68.
283. Visitors' Book 1869-87, entry for 1 June 1886.
284. Journal of Mental Science, 32 (1886), p.301.
285. Visitors' Book 1869-87, entries for 20 September 1859, 30 January 1875 and 25 June 1879.
286. For evidence of gratitude and advice-seeking amongst patients and their relatives, see Case Books 2, p.149; 3, p.10; 4, p.114; 5, pp.17 & 23; and 26, p.7.
287. ibid. 22, pp.93-5.
288. Alan Gauld, loc.cit. note 273; Gauld quotes this letter as reading 'Trewington tells me ...', but this was almost certainly a misreading of the manuscript original.
289. Quoted in J.P.Williams, 'The Making of Victorian Psychical Research: an Intellectual Elite's Approach to the Spiritual World' (Cambridge University PhD thesis, 1984, p.126.
290. Alan Gauld, op.cit. note 273, p.122.
291. ibid., loc.cit..
292. ibid., p.117 and Case Book 22, p.104.
293. ibid., pp.93-5.
294. G.F.Blandford, a London consultant, certified 17 admissions to Ticehurst (Registry of Admissions, 1845-81, case no.443; Register of Admissions, 1881-90, case nos.462, 493, 522, 529, 540, 562, 567, 575, 582, 591, & 605; and Register of Patients, 1890-1907, case nos. 609, 664, 701, 711 and 831.

295. Times, 11 March 1885, p.9.
296. Register of Admissions, 1845-81 and 1881-90, for example case nos. 92, 101, 110, 112, 115, 129, 147, 164, 192, 232, 245, 296, 336, 476, 502, 521, 556, 591, 617 & 711.
297. For example F.S. was confined to the grounds after attempting to post a letter which had not been approved by the Newingtons, Case Book 32, p.246; see also the discussion of patients right to send letters in op.cit. note 238, p.
298. Nancy Tomes, 'The Persuasive Institution: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1841-83', (University of Pennsylvania PhD thesis, 1978), p.13.
299. Andrew Scull, Museums of Madness. The Social Organization of Insanity in Nineteenth-Century England (London: Allen Lane, 1979), p.208.
300. Laurence Ray, 'Models of Madness in Victorian Asylum Practice', Arch.Europ.Sociol., 22 (1981), pp.261-2; Anne Digby, op.cit. note 50, p.219.
301. ibid., p.231.
302. [Herman Charles Merivale], op.cit., note 159, p.41.
303. David Verey, op.cit. note 54, p.7.
304. H.F.H.Newington and A.S.L.Newington, op.cit. note 5, p.68.

CHAPTER 4: 'A TORY BOTH IN POLITICS AND IN MEDICINE' -

HERBERT FRANCIS HAYES NEWINGTON'S

CO-PROPRIETORSHIP OF TICEHURST, 1875-1917

1) The Newington Family and the Asylum

When Samuel Newington died in July 1882 there was no shortage of heirs to his estate, or possible successors to his work at the asylum. Apart from his two sons Alexander Samuel and Theodore, who were medically qualified and already worked at Ticehurst as assistant physician and resident medical officer respectively, another of his sons, Walter James, managed the asylum's seaside extension at St Leonards. In addition, one of his daughters, Helena, had married a doctor with an interest in psychological medicine: George Montague Tuke - who was no known relation to the Tuke's of York or Manor House - had been an assistant medical officer at Ticehurst before he settled into general practice at Staplehurst in Kent. Although the prosperity of the 1860s and 1870s meant that the estate Samuel left was almost twice what his brother Charles Hayes' had been nearly twenty years earlier, at just over £10,000 it scarcely enabled him to make lavish bequests to his wife and twelve surviving children. Indeed, when his fortune is compared with that of another of his brothers Alexander Thurlow, who had worked as secretary to the asylum but had no children, and left nearly £24,000 to

his nieces and nephews in 1898, it seems likely that much of the £1,800 annual salary which Samuel had paid to himself by the 1870s went on raising and educating his children.¹

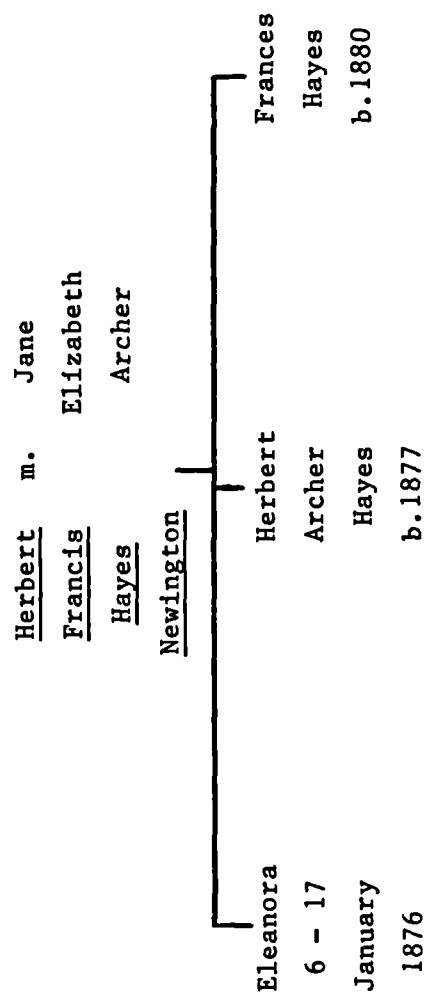
In his will, Samuel named Alexander Samuel and Theodore as successors to his work at the asylum, but established a family trust to whom the profits from his half of the business were to be paid, and who were empowered to appoint other medical superintendents if they wished. For reasons which are unclear, two codicils which were added to his will in the last months before he died excluded Alexander Samuel from the board of trustees, and instead appointed Theodore and one of Samuel's sons-in-law, Revd Algernon Parfiter, alongside Walter James and Theodore's twin Campbell. This trust had the responsibility of ensuring that the complex division of Samuel's share of the asylum's profits into three hundred parts, to be distributed in varying proportions to his twelve children depending on their marital status and whether or not their mother was still alive, was carried out as he had wished. In his desire to be equitable to all his children, Samuel thus created an unwieldy financial structure which opened the way to disunity in the asylum's administration.

Both Alexander Samuel and Theodore had taken degrees at

Cambridge before going to St Thomas' to study medicine. Although Alexander was five years older than Theodore, after leaving school he spent four years in India as a planter, so that he entered Caius College in 1868 only one year ahead of the twins.² However, since Alexander studied for an MB rather than a BA, he was able to take his MRCS in 1874, four years before his brother. At St Thomas' both Alexander and Theodore could have attended lectures on mental diseases by William Rhys Williams (1837-93), then resident physician and medical superintendent at Bethlem. Certainly both worked under him for a time there, as assistant physician and assistant surgeon respectively; and in the late-1870s Rhys Williams visited Ticehurst as a consulting physician. Amongst their other colleagues at Bethlem was a young assistant medical officer, George Henry Savage (1842-1921), who later became a prominent consultant medical psychologist in London, and referred many patients to Ticehurst.³ Alexander also worked as a house physician at St Thomas', and wrote a thesis on 'Puerperal Insanity', although he does not appear to have been awarded an MD. Through this work he became friendly with the prominent gynaecologist and obstetrician Robert Barnes (1817-1907), whose daughter Mary he married before moving into general practice in Oxfordshire for a few years. Theodore stayed at Bethlem until he returned to Ticehurst in 1879, where he took over as resident medical

officer when Francis Wilton retired.

In contrast to his cousins' gentlemanly educations, Herbert Francis Hayes Newington took the less expensive course of studying for his MRCS(1871) at University College London. Although it is possible that he could have heard Henry Maudsley, then Professor of Medical Jurisprudence at UCL, lecture on insanity, he made no later references to his time at UCL as having been formative to his education in medical psychology. Instead he always referred to the influence of David Skae, under whom he worked as an assistant medical officer at Morningside Asylum in Edinburgh whilst studying for his LRCP(1873), and Thomas Clouston whose senior assistant physician he became at the same asylum. Unlike his cousins, who wrote only one article each, and chose like Samuel Newington to publish in the general medical press rather than the Journal of Mental Science, Hayes Newington contributed several clinical papers in the early 1870s. He was no doubt aided and encouraged in this by Thomas Clouston, who was co-editor with Henry Maudsley of the JMS (see Appendix 1).⁴ In addition, Hayes Newington became a keen member of the Medico-Psychological Association, and eventually succeeded Clouston as President in 1889-90. Although Alexander Newington occasionally attended meetings of the MPA in London, and was a more regular attender at



Newington Family Tree VI

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H. P. ROBINSON

TUNBRIDGE WELLS.

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Plate 9: H.F.H. and Elizabeth Archer Newington with
their two children, Herbert Archer and Frances

meetings of the association's south-eastern division, neither of Hayes Newington's cousins took as much interest in maintaining a sense of corporate professional identity as he did; and it seems likely that Hayes Newington initially sought such wider professional confirmation to ballast his less secure social and financial position.

However, it would be misleading to exaggerate Hayes Newington's insecurity relative to his cousins. In 1875 he married Jane Elizabeth Archer, daughter of a Professor Archer who was director of the Edinburgh Museum of Arts and Sciences, and moved to Ticehurst to begin work at the asylum. As co-partner to his uncle, he was entitled to the same salary of £1,800 p.a., in contrast to the £200 p.a. paid to Theodore as resident medical officer in 1881.⁵ Joining the national middle-class trend towards smaller families, after the death of their first child in January 1876, Herbert Hayes and Jane Newington had only two children (see Plates 8 and 9, and Newington Family Tree VI). Although it is unclear to what extent Hayes Newington was expected to contribute to the maintenance of his mother, brothers and sisters as well as his wife and children at this time, by the late 1880s he had accrued sufficient capital to build a new house for himself, the Gables, as Alexander Samuel did at the Woodlands in the early 1880s. More importantly, Hayes

Newington had already worked at Ticehurst for four years before he was joined by either of his cousins, and was thus a more experienced administrator; and, unlike the joint decision-making by which his cousins were bound, he appears to have had complete control of his side of the family's 50% share of the business.⁶ In these circumstances, even without the kudos of his enhanced professional standing, it is hardly surprising that it was Hayes Newington who came to dominate the asylum's administration during the last thirty-five years that it was run as a family business.

Hayes Newington's commitment to an active professional life did not mean that he played a less prominent role in the local community, and like his cousins he devoted a considerable amount of time to parochial activities. Apart from the asylum's 300 acres, the farm-land owned by individual members of the Newington family placed them amongst the parish's largest land-owners. Following Samuel's death in 1882 Georgiana commissioned a stained-glass window in Ticehurst Parish Church of Sarah, Abraham and Isaac to commemorate him and the one son they had lost in infancy. When county councils were formed in 1888 Hayes Newington was elected as a Conservative member for the Ticehurst division. In 1893 Campbell Newington made a prosperous marriage which enabled him to extend the farm-land on which he bred prize-winning Sussex

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cattle, South Downs sheep and Sussex spaniels. He became a JP, and made generous gifts to the parish, paying in 1899 for a village institute to be built which is still one of Ticehurst's most prominent buildings, and in 1910 for a drill hall and rifle range. The parish magazine, Home Words, noted not only these major contributions but many minor donations, as when Hayes and Alexander Samuel gave £10.00 each to pay for village festivities to celebrate the wedding of the Duke and Duchess of York in 1893. Alexander Samuel's obituary in a local paper noted that he had been a member of:

the Council of the Ticehurst Institute...a Parish Councillor, a Manager of the Schools, was on the Committee of the local Flower Show, ...was a Vice-President of the Ticehurst and District Junior Football Club, and was a liberal subscriber to all local and parochial objects and institutions.

Hayes Newington, who was a keen amateur musician and gardener, conducted concerts in the parish church, and was president of the local horticultural society.⁷

As must have been the case since the asylum first opened, the Newingtons provided important opportunities for employment to the local community. In 1900 Alexander and Hayes Newington noted that:⁸

We have now two nurses, and we had two others, making four sisters with us at one time, whose father is enjoying a pension after many years service on the male side, and his father before him was in service near the beginning of the century. We have also father and son as attendants on

the gentlemen. We are fortunate in having in the neighbourhood women who have married after being in our service. These are very useful in cases of emergencies or holidays.

Whilst the Newington's economic power gave them considerable control over the villagers' behaviour - the institute, for example, had a bar for light refreshments but no alcohol - they also helped provide important services locally, as when Georgiana sat on a committee to organize a rota of nurses to attend home confinements in the parish.⁹ Clearly the training nurses received at Ticehurst could become a resource to the local community, and the convenience Hayes Newington described as being enjoyed by the asylum's administrators was to some extent reciprocal.

Despite the fall in the asylum's profits associated with the economic depression of the 1880s, what profits there were continued to be re-invested in the fabric of the asylum. In 1882 Prospect House, which had belonged to the Newingtons for some years, and had been rented out to a patient's family who wanted to live near the asylum before Hayes Newington moved into it in 1875, was added to Ticehurst's licence. The Vineyards was renovated in 1887, and Quarry Villa was extended in 1888. In the same year, Alexander Samuel's home, the Woodlands, was added to the licence; and in 1889 a new purpose-built house, Westcliffe, was opened at St Leonards in place of the

houses which had previously been rented there. Although the Lunacy Act of 1890 forbade the issuing of new licences or any expansion of the institution in terms of numbers, in 1893 an extension was built onto Hayes Newington's new house, the Gables, and included in the licence, presumably in lieu of Prospect House which was no longer used by the asylum, and may have been pulled down.¹⁰ However this expansion of space did not lead to an increase in the number of patients resident in the asylum. Between 1 August 1885 and 31 July 1915 admissions, and the number of patients resident in the asylum, remained fairly constant (see Tables 24 & 25). As Hayes Newington explained in 1900: 'our numbers have slowly increased as additions have been made, but disproportionately, for each patient requires more space as years go on'.¹¹ Following Georgiana's death Ridgeway, which had been licensed in Samuel Newington's lifetime, was used to accommodate an English duke who was admitted to Ticehurst in January 1899; and the sole occupant of the new extension to the Gables was an Egyptian prince, Ahmed Saaf ed Din, who became a patient in July 1900. Despite the increased space made available to patients, average fees remained at a similar level of £300-£400 p.a. throughout these 30-35 years, but those who were accommodated singly did pay more: thus in the early 1900s Prince Ahmed paid just over £2,000 p.a..¹²

In addition to this expansion of residential space, considerable alterations were made to the asylum's other facilities. In the late 1880s the kitchens in the main building were replaced with new equipment, and in 1893 those at the Highlands were similarly refurbished, and new offices were built. A French chef was engaged at a salary of £150 p.a., plus board and lodging, to supervise the preparation of food. In the same year the entertainments hall in the main building was re-decorated, and a drop-curtain installed on the stage; and in 1895 a ballroom was added to the Vineyards. Between 1896 and 1900 new toilets and bathrooms were fitted in the main building, and central heating was installed on the men's side. In the early 1900s a further residential unit was added to the Highlands, and new staff-quarters were opened in the main building. The safety of the patients was also given increased attention, and on the advice of the lunacy commissioners new fire exits and escapes were constructed.¹³

For reasons which are unclear, in 1893 the assistant medical officer, John Henry Earls, took over as resident medical officer at Ticehurst, and Theodore went into virtual retirement at Broomdene Farm at the age of forty-two. Since he had not married, and there was no financial necessity for him to work, the simplest explanation might be that, like his father, he lacked a

profound interest in mental disorders, and found as time went on that he preferred to spend his time on other things. With his brother and cousin to supervise the running of the institution there was little scope for a third superintendent. Of the eight resident medical officers who were appointed before 1917, six had had previous experience of working with the insane, mostly in county asylums, although Gerald Herbert Johnston and John Basil Walters came from the same private asylum at Bailbrook House in Bath. Only four ultimately remained in psychiatry, including Dr Colin F.F.McDowall, who stayed on as resident medical superintendent after Hayes Newington's death. Three of the others moved into general practice, and George Fletcher Collins became an MOH. Of those apart from McDowall who stayed in asylum work, John Henry Earls and Gerald Herbert Johnston worked in the private sector at Fenstanton, Streatham (formerly Earls Court House) and Brooke House, Clapton respectively; and Edward Hope Ridley was employed at Portsmouth Borough Asylum. (See Appendix 2).

2) H.F.H.Newington's Career and Medical Theories

1) Royal Edinburgh Asylum (Morningside), 1871-5

As a young trainee physician at the Royal Edinburgh Asylum, Hayes Newington had the opportunity to walk the wards with a former president of the MPA, David Skae. Although later in life Hayes Newington was extremely

critical of Skae's abilities as an administrator - he described Morningside at this time as 'one of the very worst asylums' which had taught him 'a valuable lesson in what to avoid' - he admired Skae's clinical acumen, and retained a life-long respect for his system of classification of insanity.¹⁴ This system, which Skae first published in his presidential address to the Medico-Psychological Association in 1863, emulated that of the French alienist Benedict Morel (1809-73) in placing a strong emphasis on an aetiological nosology. Whilst Morel's work stressed the importance of hereditary transmission in a manner which was more strongly taken up by other British psychiatrists such as Henry Maudsley, Skae's system of classification linked the onset of mental disorders to specific organic pathologies or the physiological crises of the normal life-cycle. Thus he classified insanity either in terms of a distinct physical disease or diseased organ - syphilis, rheumatism, anaemia, diabetes, Bright's disease, goitre, uterine insanity etc. - or by the stage of life which the individual had reached - young childhood, puberty and adolescence, pregnancy, lactation, the climacteric and senility. This strong physiological schema did not include moral insanity, and emphasised that alcoholic insanity was a form of toxic insanity, like lead poisoning; although in Morel's degenerationist theories such physiological corruption could initiate a downward

spiral of mental and moral deterioration which would be passed from one generation to the next. In choosing to write his first papers on cases in which an underlying organic pathology was clearly indicated - syphilitic insanity, hemiplegia in the insane and stupor - Hayes Newington was evidently seeking to root himself in this physiological tradition. Indeed, the links between syphilis and insanity had been of particular interest to Skae, who had spent his early career working in a Lock hospital.¹⁵

Hayes Newington's paper on 'a Case of Insanity dependent on Syphilis' presented a multifactorial analysis of the disease's aetiology which was characteristic of what came to be known as the 'clinical method'. Thus no hereditary predisposition was ascertainable in the case of 'Mrs J.H.', although Hayes Newington made it clear that if such a predisposition had been present it would have been considered the prime cause, but instead a syphilitic infection received early in her adult life was seen as having lain dormant for over thirty years until the physiological stresses of the climacteric precipitated the growth of a syphiloma in the brain which was believed to have caused the present outbreak of insanity. Although this aetiology was primarily physiological, environmental stresses and the patient's former behaviour were also seen as having a role to play in the possible

sequence of causes. Thus Skae had included 'Masturbational Insanity' in his system of classification; and Hayes Newington saw 'Mrs J.H.'s' ability to rear four of her eight children to adulthood, despite being separated from her violent husband, as evidence that the original syphilitic infection had been limited in extent, since such 'a life of struggling ... would certainly find out mental defect'.¹⁶ However, even when symptoms were perceived as being mental in origin, their effects were sometimes traced through physiological causes. Thus Hayes Newington saw cases of temporary and limited hemiplegia in the insane, which were soon to become the subject of great controversy through the publication of Charcot's work on hysterical paralysis, as a result rather than a cause of insanity; but he hypothesized that the transient and intermittent nature of these attacks could be explained if they resulted from an effusion of serum, rather than blood, from the cerebral vessels.¹⁷

More importantly, the patient's behaviour before the outbreak of their disorder, and vulnerability to stresses and temptations in the environment, were themselves seen as a product of the patient's inherited constitution. Thus the onset of the two types of stupor which Hayes Newington differentiated could be precipitated by, in the case of what he called 'anergic' stupor, a sudden and

intense shock, convulsions, acute mania or prolonged nervous exhaustion; and in the case of what he called 'delusional' stupor by melancholia, general paralysis or epilepsy. But both were seen as requiring a 'very marked' hereditary predisposition. The hereditarian aspects of Morel's psychiatric schema were more extensively discussed and taken up by Skae's successor at Morningside in 1873, Thomas Clouston. As well as working under Clouston, Hayes Newington had the opportunity to hear him lecture, and compared 'the living forcefulness of Clouston's clinicality' very favourably with the more academic and professorial style of Thomas Laycock (1812-76), whom Clouston ultimately succeeded as Edinburgh University's lecturer on medical psychology and mental diseases.¹⁸ Clouston's emphasis on the hereditary transmissibility of mental, as well as physical, characteristics undoubtedly influenced Hayes Newington. In a paper on 'mania-à-potu' which was read to a meeting of the Medico-Psychological Association in Edinburgh in January 1875 on Hayes Newington's behalf by a colleague of his at Morningside, James McLaren, Hayes Newington stressed that mania-à-potu, defined as 'a transient and violent mental disturbance...occasioned by a dose of alcohol utterly inadequate to upset a sane person' generally afflicted individuals who 'had a brain constitution that would not allow [them] to be steady ... and may be said never to attack a person who has led

anything like a moral life up to the time of seizure'.¹⁹

Whilst degenerationist psychiatric theory thus provided biological rationales for moral precepts Clouston's hereditarianism stopped short of a fatalism which would have restricted psychiatry's potential to a purely descriptive science, and psychiatrists' role in society to one which was merely custodial. W.F.Bynum has rightly argued that as well as addressing areas of social concern 'hereditarianism appeared to some psychiatrists as more genuinely scientific because it offered the possibility of aetiological nosologies'; and whilst German Berrios somewhat whiggishly sees Hayes Newington's categorisation of different forms of stupor as having been handicapped partly because he 'wrote in a pre-Kraepelian world in which the fundamental distinction of the two major psychoses had not yet been made', Newington's clinical-method case-histories were sufficiently closely observed for Berrios to be able to state with confidence that 'most of [Newington's] cases describe 'catatonia-like' states'.²⁰ The intention behind taking such comprehensive case-histories was ultimately the hope that they would shed light on the prophylaxis and cure of mental disorders. Clouston's work from the 1880s onwards increasingly focused on what could be done through mentally-hygienic education to prevent the development of insanity. But for the purposes of this study, it seems

more important to explore how the limited human potential Thomas Clouston and Hayes Newington felt they were working with affected their therapeutic practice as asylum superintendents.²¹

The new emphasis on heredity as a causal factor in mental disorders challenged the kind of optimistic outlook which had informed Samuel Newington's work at Ticehurst, that there was a natural tendency to health in the patient which the physician needed only to work with and support in order for the patient to have a good chance of recovery. Instead, hereditarianism posited an innate potential for disease, which it was the physician's responsibility to inhibit or, when a mental disorder had already developed, undermine. However, since the manner in which patients were affected by their heredity was construed firstly in terms of a deficiency of nervous strength, and secondly in terms of a natural tendency to form bad habits, the treatment Clouston prescribed for patients at Morningside was a combination of supportive medical treatment and moral therapy which had much in common with the treatment of patients at Ticehurst in the early 1870s. As Margaret Sorbie Thompson's history of Morningside has shown, Clouston paid great attention to the physical comfort and cheerfulness of the patients' environment; and he arranged outings and entertainments to divert their minds. Although he used some drugs,

notably bromides, he was particularly sceptical of the value of opium. The most fundamental precept of the medical treatment he advocated was the importance of nutrition: 'Fatten your patient and you will improve him in mind'.²² The only important way in which treatment at Morningside differed from therapy at Ticehurst was that Clouston's patients were encouraged to work as a further mental diversion, but, given the unsuccessful efforts which Samuel Newington had made to interest his patients in gardening, this is probably best explained by the class difference between patients at Ticehurst and most of those at Morningside.²³

Hayes Newington's descriptions of treatment in his early papers confirm this general framework: only 'Mrs J.H.' was given potassium bromide and potassium iodide; whilst stuporous patients were prescribed tonics (such as iron and aloes), force-fed if necessary, and given porter and ale as stimulants. In addition in his paper on stupor Hayes Newington emphasised the importance of moral treatment, suggesting that 'no medical treatment is of use unless it is well backed up by moral pressure'.²⁴ Although his description of the stuporous patient's mind as a 'tabula rasa' highlighted the patient's apparent absence of will-power in a manner which was antithetical to Thomas Mayo, Newington's belief that stuporous patients were 'without the power to recognize and avoid

what is harmful' sounds close to Mayo's assertion that the morally insane suffered from an innate lack of moral sense, although it is clear that Newington regarded this absence as only temporary in many cases, depending on the degree of innate impairment and the speed with which patients received treatment. His emphasis on the rather automatic way in which these patients imitated those around them, and the importance of providing people who displayed 'industry and correct habits' as models, suggests that the way in which medical psychologists understood how moral treatment might be effective continued to be informed by reflex psychology.²⁵ In the next section the extent to which these continuities left room for change in the treatment of patients at Ticehurst during the forty-two years for which Hayes Newington was joint-proprietor will be discussed.

11) Treatment of Patients at Ticehurst

The first case-history which Hayes Newington published from Ticehurst, in 1877, reflected his continuing commitment to an exploration of cases with an evident organic pathology, as well as the ease with which, despite his new theoretical approach, he could work within the traditions of treatment which had been established at Ticehurst. His description of a 'Case of an Extraordinary Number of Convulsions occurring in an Epileptic Patient' gave an aetiological account of the

patient's disorder, which stressed that her poor heredity meant that she had been 'an emotional and wayward girl' even before the onset of epileptic seizures 'slowly carried' her 'mind...on to insanity'. Whilst Hayes Newington's initial failure to diagnose the nature of these seizures, which she had at first only at night, because 'none of the nurses who sat up with her could describe [them] in such a manner as to give us sufficient grounds for diagnosing their nature' suggested a limited clinical curiosity, his description of her later fits - in which she lost consciousness, her head was drawn to one side, her jaw was drawn down, the muscles of her chest became fixed, and clonic spasms were confined to the muscles of her face and neck - was rich in clinical detail in a manner which contrasted with Samuel Newington's case-notes.²⁶ However unlike Hayes Newington's paper on hemiplegia, or a paper on epilepsy by his former colleague at Morningside James McLaren, in which McLaren raised as problematic the absence of a theoretical understanding of what kind of organic changes underlay epileptic patients' symptoms, this paper did not hypothesise about what might be happening in 'Miss X.Y.'s' brain or nervous system.²⁷ Nor is it clear whether or not Hayes Newington was familiar with Hughlings Jackson's earlier suggestion that epileptic convulsions resulted from an excessive and disorderly discharge of nerve-tissue on muscles, caused by lesions

in the patient's corpus striatum or cerebral cortex.

Instead, Hayes Newington focused in this paper on what kind of therapeutic response best aided epileptic patients, suggesting that medicines, including bromides, were of little value, and emphasising the benefits of supporting the patient's ability to withstand convulsions through proper nourishment. Although no doubt influenced by McLaren, who had suggested that counter-irritation could be useful in cases of epilepsy, Hayes Newington blistered Elizabeth Beeching's neck, a practice which had become uncommon at Ticehurst by the 1870s, he dismissed this, like bromides, as of little benefit, and argued that:²⁸

With regard to attempting to stay the disease with medicine, &c., the best plan, I feel sure, is to throw it all to one side as more likely to do harm than good, and to devote all one's energies to the administration of proper and sufficient nutriment.

Since Elizabeth Beeching suffered from severe stomatitis, so that feeding by mouth was impossible, she was fed with a nutrient enema of 'one egg, one ounce of brandy, and one ounce of a strong mixture of Liebig's extract' every five hours, surviving eight days of mild epileptic fits occurring every 2-5 minutes. On the basis of this case Hayes Newington argued that many lives were needlessly lost through an absence of sufficient nourishment, when with due care not to irritate the bowel by changing the

composition of the enema or including chemical agents such as hydrochloric acid or pepsine, patients' bodily strength could be maintained even when feeding by mouth was no longer possible. To prevent the bowel rejecting the nutrient enema he recommended it should be thoroughly cleaned out with a soap-and-water enema before the nutrient one was given, and that if necessary the anus should be plugged after its injection with a sponge soaked in oil.²⁹

In a shorter paper which concentrated exclusively on the technicalities of force-feeding, written in 1879 whilst he was still at Bethlem, Theodore Newington described an instrument he had designed for feeding patients by the nose. Like his grandfather Charles in 1826, Theodore emphasised that the method of force-feeding he favoured was 'the cleanest and quickest way' involving 'least struggling on the part of the patient and medical attendant'. He claimed that the advantages of the instrument he had designed (which had a central ball of vulcanite to which three tubes were attached, two of which were inserted through the nostrils, the third being attached to a funnel into which liquid food could be poured) were that there was less likelihood of damaging patients' mouths and teeth in the struggle to feed them; that it took only three minutes to feed a patient by this method; and that the patient was less likely to gag and

vomit than when a tube was passed through their mouth. As in the method of feeding described by Charles Newington, Theodore recommended that patients should be lying down when they were fed, but instead of being held down by attendants, one of whom would hold the patient's head still, he suggested that the patient should be fastened in bed with a sheet, the medical man 'steady[ing] [the patient's] head with a towel over the forehead and kneeling on the ends of the towel' while the food was administered.³⁰ In the more genteel ambience of Ticehurst however most patients who refused food continued to be fed with the stomach-pump rather than through the nose. Only those cases where the refusal of food was perceived as wilful were fed with a nasal tube; thus in 1895 K.M., who shortly after admission had warned Alexander Newington that she would 'give all the trouble [she could] ... it [was] merely a matter of who would last longest', one day after she had begun to refuse food, threatening to 'go on to the verge of death', 'expressed great disappointment that she was not fed by the stomach tube. The nasal tube ... [was] more unpleasant'; and after being force-fed one more time she started to '[take] her food well', although she now refused to talk, or wash or dress herself, and had to be carried everywhere because she would not walk.³¹

In addition to force-feeding patients who refused food,

the Newingtons were keen to make sure that patients who ate normally were able to digest and get full benefit from their food. A paper by the resident medical officer at Ticehurst, Francis Wilton, published in April 1880 described the treatment which had been pursued in 'A Case of Obstinate Constipation and Inactivity of the Liver'. 'M.D.' - Marianne Dalton - was force fed as well as being given several enemas, since her sluggish digestion meant that she sometimes had little appetite for food. This case is interesting since it makes clear that medicines were sometimes given, seemingly without the patient's knowledge, with food. Thus in addition to the enemas, Marianne Dalton was prescribed a sedative, chloral hydrate, which was given to her on a piece of bread and butter; and a cholagogue, podophyllin, which was put in the three glasses of port wine which she was encouraged to drink each day. Although this means of administering medicine to patients who refused it was more subtle than the forcible medication described by Anne Digby at the Retreat, it suggests a similar departure from the fundamental emphasis placed on respect for the patient in early moral treatment, and the coaxing methods used at Ticehurst by Robert Hervey in the 1830s. Even patients who became voluntary boarders after the permissive legislation of 1890 were sometimes given medicine concealed in food: thus when one voluntary boarder, L.B.T., refused any medicine in September 1911, an

aperient was mixed with her next meal. An experienced patient, who had been in and out of Ticehurst for over twenty years, L.B.T. refused the food as well. She was not force fed, but a few days later, after she had thrown a glass of lemonade at Hayes Newington and threatened her attendant with a knife, she was placed under certificates.³²

What it seems important to emphasise about Marianne Dalton's case-history, and that of Elizabeth Beeching, is that although both were published in the Journal of Mental Science they dealt almost exclusively with the importance of maintaining patients' physical health, and were viewed as successful despite the fact that in Elizabeth Beeching's case there was no improvement in her mental condition, and Francis Wilton gave no details of Marianne Dalton's mental state, except when she was described after treatment as able to '[read] or [do] a little plain work' - and this could have been intended as an indication of returning physical strength rather than, necessarily, an improvement in her mental condition.³³ Indeed, since Marianne Dalton had been transferred to Ticehurst from another asylum six years previously, and was nearly seventy, it seems likely that little improvement was anticipated in her mental health. Whilst this attention to the patients' physical well-being is understandable in so far as both patients' lives were

potentially threatened by their disorders, it also reflected the extent to which an emphasis on heredity could reconcile late-Victorian medical psychologists to the limited mental benefits of the psychophysiological approach.

How did this more biologically-determined view of mental disorders affect moral therapy? As Anne Digby's study of the York Retreat has shown there could be strong institutional reasons why a gentle fostering of patients' desire for esteem should have become routinized into a more coercive manipulation of privileges and punishments. Although there was no ward-system at Ticehurst into which patients could be graded depending on their behaviour, patients continued to be transferred from the smaller villas to the main building, and within the main building, if their behaviour deteriorated. Throughout the 1880s and 1890s seclusion was occasionally resorted to, but the only mechanical restraint used was the mustard pack, which was believed to be of therapeutic benefit as well as simply restraining.³⁴ The case of Emma Willoughby Osborne illustrates well some of the tactics which were used to discourage violence and encourage co-operative behaviour. On admission in December 1880, Emma Osborne was excited and violent, smashing cups and glasses and refusing food. She was purged with calomel, and sedated with morphia, and became

quieter. After a few days however she took a dislike to one of her attendants, smashed a candlestick and barricaded herself in her room, hitting Theodore Newington in the face when he came to see her; following this incident she was 'put to bed' - presumably restrained by a sheet, although no entry to this effect was made in the Medical Visitation Book. Sedated again with morphia, she improved to the point where she was allowed to go to church and attend entertainments in the asylum. However when she smashed a window with her umbrella, her walks were restricted to the grounds of the asylum, until she improved sufficiently to be transferred to Quarry Villa, was allowed to go on day-trips to Tunbridge Wells and St Leonards, and subsequently discharged. Re-admitted to Quarry Villa one week later, she again became excited, throwing stones at Hayes Newington, and was returned to the main building. After she overturned and damaged the piano in her room, she was once again sedated with morphia and purged with calomel; and when she became excited three months later, the furniture was removed from her room in anticipation of the damage she might cause, and she was secluded. Following news of her husband's death shortly after this she spent a week locked in her room on account of excitement. When she subsequently managed to pull down a marble mantelpiece and smash it to bits, the Newingtons asked her relatives to remove her from Ticehurst.³⁵ The

reliance on chemical sedation in the absence of mechanical restraint which is illustrated in this case-history will be explored in more detail below; here it is worth noting that Emma Osborne's ultimate removal reflected how strong the Newington's determination to maintain a genteel ambience at Ticehurst was, even if it meant admitting an inability to control some patients. Two other female patients were also removed from the asylum at the Newingtons' request after smashing furniture in their rooms.³⁶

This system of progressive exclusion or inclusion depending on behaviour represented less of a departure from the original tenets of moral treatment at Ticehurst than the increasing disciplinarianism at the Retreat did from Samuel Tuke's therapeutic philosophy. As was stressed in Chapter 2, Thomas Mayo's contract of cure always depended on the threat of increased coercion, and a retraction of privileges. By the 1880s however what was at stake was not so much exclusion from contact with the Newington family - although some convalescent patients were invited to dine at the Gables or the Woodlands - but the degree of comfort, and opportunities for outings and entertainment, in the patients' surroundings. As at the Retreat, a clearly defined pattern of giving and withdrawing privileges formed one of the main techniques of social management in the

absence of mechanical restraint. Although the Newingtons' policy had been to use very little instrumental restraint since at least the 1840s, after Hayes Newington's arrival at Ticehurst more patients were admitted in a state of acute mania without this leading to even a slight increase in mechanical restraint, such as had occurred in the late-1860s following similar admissions. Just as Mayo found he was able to deter 'N.B.' from unco-operative behaviour by threatening him with the strait-waistcoat, rather than actually using it, Hayes Newington suggested at a meeting of the MPA in 1887 that 'he probably used as little strong clothing as anyone...but...One...reason for their occasional use was to deter patients, by the sight of them, from bad habits'; although there is no evidence of what G.H.Savage described as '"bogey" dresses',³⁷ actually being used to intimidate patients in the case-notes from Ticehurst. Despite some routinization in the way in which patients were handled the generous staffing levels at Ticehurst meant that the responsiveness of different patients to particular incentives and deterrents continued to be individually assessed. Thus whilst warm baths, sometimes with cold to the head, were used to soothe patients in a state of hysterical mania, in 1883 a bulimic patient called William Carter, who disliked warm baths, was told that if he vomited after eating he would be given a bath at bed-time, and this encouraged him to retain his

food.³⁸

A harder question to answer is how far the more organized use of privileges and punishments to manage patients reflected a decline in therapeutic optimism, and a view of the asylum as simply containing. Historians have suggested that the overcrowding of public asylums and apparent increase in insanity made late nineteenth-century medical psychologists responsive to hereditarian explanations of the cause of mental disease; and although increased space and the death of many long-stay patients at Ticehurst meant a peak of new admissions between 1875 and 1885, only about one quarter of first admissions between 1875 and 1915 were eventually discharged 'recovered' (see Table 24 & Figure 11).³⁹ In 1884, Hayes Newington published a paper on 'Unverified Prognosis' which listed hereditary predisposition as the prime determining factor of the course an outbreak of insanity would ultimately take. Whilst this paper reflected the strong influence of degenerationism on Hayes Newington's view of insanity - in it he described one four-generational family history taken at Ticehurst as demonstrating 'the tendency to extinction of the race' - he also emphasised the difficulty of obtaining a full family history from which to make an accurate prognosis. Thus although hereditarian ideas may have helped lower therapeutic morale it seems unlikely that, unless a

distinct family history was known, they would have been a determining factor in the course of treatment.⁴⁰

However, the elision of moral and medical values in degenerationist psychiatry did help foster a renewed emphasis on the importance of the use of discipline in the moral management of the insane.

Hayes Newington's philosophy of moral treatment sanctioned the use of fear and the threat of unpleasure in establishing authority, as Thomas Mayo's had, but his understanding of 'moral insanity' was in some ways different. The increasing emphasis on heredity might have been expected to lead to a renewed interest in the idea of an innate absence of moral sense in patients who were 'morally insane'. In his Clinical Lectures Clouston had suggested that whilst no moral sense had been localised in the brain, and 'There is of course no proof of mental inhibitory centres;...there is mental inhibition, and a function always implies an organ of some sort'. In 1887 he elaborated this idea to the M.P.A. by suggesting that:⁴¹

Looking at morality in a practical way, they found the moral sense a physiological brain quality, developed as the muscles were developed, perfected as the muscles were perfected, yet differing in different individuals. Certain predisposed children were capable of development intellectually and morally to a certain extent only... They were only capable of development up to a kind of semi-savage stage in this direction, while their reasoning powers were the same as other children.

Other late-nineteenth century medical psychologists like G.H.Savage and J.Shaw Bolton (1867-1946) distinguished between an innate lack of moral sense, called 'primary moral insanity' or 'moral imbecility', and an acquired and temporary deficiency of self-control due to some other mental or physical disorder, called '(secondary) moral insanity'.⁴² Descriptions of cases of the latter kind were also informed by evolutionary theory, but emphasised not so much the inheritance of mental and physical characteristics as a Spencerian hierarchy of instincts and faculties in which the moral sense - as one of the most highly evolved faculties - would naturally suffer first from any organic dissolution or disease. It is clear from Hayes Newington's 1887 paper on 'The Tests of Fitness for Discharge from Asylums' that he believed not only that some patients suffered from 'a congenital weakness of self-control', but that 'the higher one gets in this scale [from the lower instincts to moral sense]...the more readily do we see the emotions fall prey to mental disease'.⁴³

As Michael Clark's paper on 'The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century Britain' has shown, despite the fact that disorders like 'moral insanity' and 'hysteria' - described by G.H.Savage in 1887 as 'functional' in contrast to disorders caused by structural defect or

disease of the brain or nervous system - were perceived as 'genuine diseased conditions', the attitude of late-Victorian medical psychologists to patients suffering from these disorders was often one of moral censure. Whilst the elision of moral and medical values in evolutionist psychiatry provided one intellectual ramification for treating patients without what would have been seen as undue sympathy, Clark also rightly emphasises the way in which a strong assertion of the medical psychologist's 'moral-pastoral role' helped compensate for a lack of therapeutic resources in treating mental disorders of all kinds, and the particular problems posed to a physiological psychiatry by disorders for which no organic base could be found.⁴⁴ Clouston exemplified this ambivalent attitude in 1880 when he told a meeting of the MPA after a talk on Charcot's work by David Yellowlees that:⁴⁵

...he had great distrust of the whole of Dr. Charcot's conclusions. He regarded the motor phenomena as the best examples yet described in medicine of suggested motor action in hysterical subjects with unstable brains, diminished voluntary inhibition, and a morbid craving for notoriety.

If Hayes Newington had dismissed 'morally insane' patients in 1886 as 'the people in asylums whose opinions should be considered the least' when drafting lunacy legislation, in 1889 he suggested that they might benefit from being taken to see wards full of the chronically insane, as though after this moral lesson they would be

able voluntarily to step back from the brink of a slippery descent into degeneracy and madness.⁴⁶ At Ticehurst hysterical and 'morally insane' patients were handled with increasing firmness. In July 1881 an hysterical female patient called Georgina Dovrington was started on a 'new treatment':⁴⁷

Miss Hart has left, also [Mrs Dovrington's] attendant Willis, in their places have been substituted 2 mental nurses from London who have orders to treat Mrs Dovrington with a stricter hand than hitherto... There is no doubt that a great deal of Mrs Dovrington's state of mind is owing to want of self-control, which she is quite able to exercise, so it is thought advisable that those who have the management of her in future should not give way to all her whims and fancies.

Whilst there were clear continuities between this treatment and Samuel and Charles Hayes Newington's use of mechanical restraint to cultivate a reflex habit of inhibition, the distinction between higher and lower evolutionary levels meant there was also a new emphasis on the importance of establishing voluntary, rather than reflexive, control. In this case, increased exercise failed to develop the patient's mental inhibitory 'muscle', and although she temporarily improved a subsequent recurrence of her hysterical attacks led her husband to remove her from Ticehurst, perhaps unconvinced that the Newingtons attitude of 'observant neglect' had been the best treatment for his wife.⁴⁸

In his article on 'The Tests of Fitness for Discharge

from Asylums' Hayes Newington stressed the importance of the patient's ability to control themselves as one criterion for discharge. Discussing self-control in relation to patients who had been suicidal on admission he suggested that a clear awareness in the patient that suicide was morally wrong, and a restoration of good family-feeling, were definite indications of recovery since, given the evolutionary hierarchy of instincts and moral faculties, the presence of such feelings guaranteed 'that behind these are the other more substantial checks of instinct' - 'love of life and fear of death' - to resist the impulse to suicide.⁴⁹ It is understandable why he chose to focus on the prevention of suicide at this time (1887), since throughout the early 1880s there had been a spate of suicide attempts at Ticehurst, including two which were successful. Thus in January 1881 William Baldwin cut his throat with a dinner-knife; and in December 1886 Kate Philpott set fire to her night-dress, and died two weeks later of the burns she sustained. A third patient, Charles Turner, had escaped to France in September 1880 and shot himself; and in January 1882 Hugh Brodie died from pneumonia after drinking scalding tea, although it is unclear whether this was done with suicidal intentions. During the seven years 1880-6 Sarah Furley attempted suicide by jumping from a window, Captain Walsh precipitated himself head-first from a window-sill, Marmaduke Simpson threw

himself into the sea at St Leonards, Marion Collier claimed to have swallowed the pieces of her broken eye-glass, and Mary Marshall jumped into a lake near the asylum.⁵⁰ Although Sarah Furley and Marmaduke Simpson were on trial discharge when these attempts occurred, and it was precisely how to assess the risk to patients like them that Hayes Newington was concerned with in his article, the brunt of responsibility for the day-to-day safety of suicidal patients generally fell on attendants in the asylum.

In 1884 G.H.Savage had published an article on the 'Constant Watching of Suicide Cases' in the Journal of Mental Science, in which he argued that continual observation encouraged some patients to attempt suicide, and made it more difficult for them to build up self-control.⁵¹ At Ticehurst, however, patients who were believed to be in danger of attempting suicide were never left alone, and falling asleep whilst on night-duty with a suicidal patient was one reason why an attendant could be dismissed from the asylum in the 1880s. Following William Baldwin's death the commissioners asked that knives and forks should be counted before and after each meal, and all knives, scissors and other sharp implements should be accounted for at least once in every twenty-four hours. In July 1881 an attendant was dismissed for leaving knives out, although by June 1885

another attendant was only given a warning for a similar failure to observe these regulations.⁵² Hayes Newington was involved in preparing the Medico-Psychological Association's Handbook for Attendants on the Insane (1st edition 1885), which warned attendants of the need for watchfulness with suicidal cases. Amongst means of suicide which were specifically mentioned were burning or scalding, cutting or stabbing, drowning, falls and precipitation. The Handbook advised that suicidal patients should be accommodated on the ground floor, and seated in day-rooms as far away as possible from the windows and fireplace.⁵³ Despite all these precautions, in January 1894 a male patient at Ticehurst, S.J., died from injuries he had received by dashing his head against a marble mantelpiece. Alexander Newington, whose evident interest in the effects of specific injuries to the brain and spinal column was reflected in his only published paper on a 'Gunshot Wound of the Brain' asked for permission to do a post-mortem in this case, but this was almost certainly refused since there are no case-notes of one having been carried out.⁵⁴ The coroner's inquest held on the case cleared the attendants of any blame, but the risk of suicide continued to concern the Newingtons. In c.1906 and 1907 two attendants were each severely reprimanded, one for allowing a suicidal patient to be alone while he went to run errands, and the other for leaving a bottle of Jeyes' fluid in a ground-floor toilet

in the Highlands. The only special commendation of an attendant recorded in the Attendants Book kept at the asylum was of Henry Watts, for preventing 'a very heavy and powerful man' from committing suicide in February 1911. As a reward, Watts salary was increased; and when he later became ill with phthisis his treatment in a sanatorium was paid for by the Newingtons.⁵⁵

In addition to watching suicidal patients, attendants were expected to help create a morally wholesome atmosphere from which the patients could derive strength. Just as Thomas Mayo had suggested that 'the weak take their tone from the strong', Hayes Newington emphasised in his article on stupor that the insane needed 'good to imitate, and not bad'. Partly because of this, as well as for the obvious managerial advantages, the Newingtons sought to maintain a strict control over the habits of their employees. Drinking, in particular, was strongly disapproved of; and whilst attendants being drunk on duty posed a serious safety risk, the Newingtons also sought to regulate off-duty drinking. Thus in July 1881 an attendant called George Clegg was given a post at St Leonards 'on agreement to become a Total Abstainer'; and in 1902 an attendant called Henry Vigor, who had twice been reprimanded for drunkenness, was allowed to remain employed 'in view of his long service and family' only if he became a 'Teatotaler' (sic). When J. Bradshaw applied

to become an attendant with a reference from Wyke House private asylum which described him as 'very kind & obliging' Hayes Newington wrote back to the referee asking if Bradshaw was 'sober'.⁵⁶ It is worth noting that, although there is no evidence of conditions of employment regarding drinking in the mid-nineteenth century at Ticehurst, Thomas Mayo's 1828 praise of Charles Newington for not allowing attendants to drink suggests this may have been a long-standing policy. On the other hand, Hayes Newington could have been influenced by the large number of cases of alcohol-related insanity at Morningside, and Clouston's particular interest in the connection between alcoholism and insanity, as well as the strong emphasis in degenerationist psychiatric literature on alcoholism as a symptom of hereditary decline, to place renewed emphasis on temperance.⁵⁷

Whilst drunkenness was the most frequent reason given for male attendants' dismissal, other reasons included fighting and quarrelling; betting; 'immoral conduct with a married woman', or any woman 'he being a married man'; discourtesy to patients; appropriating food, money and clothes belonging to patients; climbing an escape ladder outside the nurses' dressing-rooms; and being the subject of a criminal investigation. Swearing, smoking and being drunk on duty sometimes led to a reprimand rather than

immediate dismissal, with attendants being placed on 'short notice', i.e. under the threat of immediate dismissal if they breached regulations again. In other cases they were deprived of leave or, in one case of stealing food, fined as a punishment. This style of management makes understandable Alexander and Hayes Newingtons' comment in 1900 that they liked to recruit male attendants:⁵⁸

...principally from the services... We make a considerable point of their having been officers' servants or mess-waiters, because, in addition to having acquired a sense of discipline and duty, they start with the great advantage of knowing how to speak to gentlemen. We do not appreciate any fancied superiority either in station or in bearing among our attendants, as it is apt to be galling to our patients.

In July 1881 an attendant called W.Walter was reprimanded for a 'want of respect towards Patients in repeatedly wearing his hat indoors in their presence; and in January 1909 an attendant called James Rigby was dismissed for 'repeated breaches of discipline in not saluting ladies as provided for in our regulations'. As the Newingtons 1900 address made clear, despite the firm handling which they believed some patients required, they viewed attendants primarily as 'body servants' or 'valets' whose moral influence could be exercised through treating patients with the deference their social standing would have commanded in ordinary life, rather than a strong assertion of authority.⁵⁹

There were surprisingly few cases of attendants being dismissed for undue roughness, or violence, in handling patients. Two male attendants, F.Wright and Sydney Hill were dismissed for assault and rough treatment of a patient in 1888 and c.1896 respectively; and George Wenbau was reprimanded in 1915 after he had been seen by the resident medical officer, Colin McDowall, behaving 'roughly' towards a patient. One difficulty is, of course, that the Newingtons may not always have been aware of incidents of violence. In December 1885 H.Baker and J.J.Sibbald were dismissed for not reporting 'ill-usage [~~crossed out~~] an accidental fall of Mr H.Wilson', a patient in the asylum.⁶⁰ Entries on injuries in the Medical Visitation Books sometimes recorded that they had been caused by attendants attempting to restrain patients, as when Mr M. received a bruise below the eye from his attendant in 1887, 'whose brains he [Mr M.] was going to knock out', and Mrs H. had her hand bruised in 1908 'in a struggle with two nurses whom she had attacked'; but many minor injuries entered in these books were described as self-inflicted following the attendants' account of the incident. Thus in January 1898 Miss M. had a 'slight black eye (right) believed to have been self-inflicted', and in April 1906 Miss B. also had a black eye which was said to have been 'caused by knocking herself against the bedstead'. Although injuries to patients were fully investigated, in most

cases the benefit of the doubt was given to the attendants. In one case the patient, a Mr Pulteney, who had received bruises in a struggle with his attendants, '[blamed] himself for this and [acquitted] the attendants of any undue violence'; but patients who chose to complain of ill-treatment were rarely taken seriously. Even after the Newingtons had dismissed F.Wright for assault, the commissioners suggested that the patient whom he had assaulted was 'prone to exaggeration, and [they could not] attribute much weight to his complaints'.⁶¹ Whilst the Newingtons were clearly anxious that their staff should use only the minimum of necessary force, some patients at Ticehurst were extremely violent, and it would be understandable if attendants who had heard stories of how, for example, in August 1884 Mary Berryman had thrown her attendant downstairs and then fallen on top of her, or L.B.T. had threatened her attendant with a knife in 1911, sometimes reacted with their maximum strength to prevent injury to themselves.

In theory, attendants were encouraged to call others for help when a patient became violent, to out-number, intimidate and pacify the patient, and administer a sedative if it was thought necessary; but in practice, even with generous staffing, as the asylum expanded in size the time-lag before other attendants could reach

them meant that they often had to act as best they could to restrain the patient by themselves. In November 1904 a female patient who a few weeks previously had 'Seized her attendant by the hair & pulled out a big bunch', 'attacked her attendant, got her down on the floor & during the struggle the patient received a black eye (Rt.) but it was not ascertained what struck it'. If the attendants were thus placed in an ambiguous position of being in service but nevertheless sometimes having to use force to control those with whom they worked, it was a dilemma which was shared by the medical superintendents. In conversation Hayes Newington's grandson Walter suggested that his grandfather's physical stature and strength had sometimes proved an asset in his work at the asylum, and that when the Egyptian prince who was admitted to the asylum in 1900 became violent towards Hayes Newington he had been able to 'peg him up against the wall' with a chair until assistance arrived. It seems important to emphasise however that the only use of force which the Newingtons sanctioned was that used in self-defence, and they attempted to weed out attendants whose volatile tempers might make them prone to violence under stress: thus apart from dismissing attendants who got into fights with each other, in 1891 an attendant who had not actually assaulted anyone was dismissed for 'Assuming an aggressive attitude' towards a patient.⁶²

The overall strictness of the Newingtons' management policy was limited by the need to maintain a staff of trained and experienced attendants. Since they preferred to recruit people with no experience of caring for the insane and train them themselves, long-term staff were given more lee-way in their behaviour. In the late 1880s an attendant called George Frank who came on duty too drunk to work the day before Christmas Eve was put on 'short notice' rather than discharged, despite a previous warning for '[chucking] the housemaid under the chin', 'on account of his long service'. If Henry Vigor was also initially only cautioned on account of his 'long service' as well as his family, he was dismissed for another incident of drunkenness in 1907 only to be re-employed amidst the staff shortages created by the first world war, in 1915. Another attendant called George Knapp who took several days off work in May 1917 claiming he was suffering from 'bowel trouble' was only reprimanded after being seen working at home in his garden, despite having had a previous warning for drunkenness. Hayes Newington told Knapp however that 'if he were not required as an experienced man he would be discharged on the spot', concluding 'He is a scamp, but a good attendant'. As the Attendants Book makes clear, some male attendants who were able to satisfy the Newingtons' strict criteria as employees used the experience they had acquired at Ticehurst to gain

employment in other private asylums, such as Manor House in Chiswick, or to work independently caring for single patients.⁶³ On average, a survey of 1898 found that male attendants worked just over ten years at Ticehurst, and female attendants five and a half years.⁶⁴

In addition to their preference for ex-service personnel, the Newingtons noted the ability to play a musical instrument or being a keen sportsman as assets when considering whether or not to employ men who had applied to become attendants. Regular exercise and entertainments continued to be an important aspect of asylum life. The asylum band played twice-weekly, and in the winter there were weekly dances, as well as occasional special entertainments. Hayes Newington's grandson Walter recalled having seen his first silent film in the 1910s in the entertainments hall of the asylum. In addition to archery, billiards, bowls, cricket, golf, running with the harriers, tennis and trips out in horse and donkey-drawn carriages, some patients went horse-riding with Theodore Newington, who was a keen rider, and 'tricycle tandems' were bought in 1891 to enable patients to go cycling without risk of being separated from their attendants. A new game introduced in the 1890s was bicycle-polo, which Alexander and Hayes Newington described in 1900 as 'a really valuable agent, as it needs such skill and direct

attention to the game that [patients'] mental idiosyncracies have little scope for action for the time-being'.⁶⁵ In a similar way, Hayes Newington's paper on 'Some Mental Aspects of Music' criticised the idea of a localised 'music centre' in the brain, which might theoretically remain completely unaffected by a patient's mental disorder, and emphasised that the complex co-ordination of functions required to play an instrument, or even to sing, was only fully achievable in a state of mental health. Although this paper does not discuss the use of music therapeutically, Hayes Newington's enthusiasm for music meant that he encouraged patients to play the piano with him, or allow him to accompany them on the piano while they played another instrument. Unlike his uncle Samuel, Hayes Newington also regularly conducted evensong in the asylum chapel. As previously, lady and gentleman companions were employed to foster patients' interest in reading, drawing, painting and sewing, and it was partly because of their presence that the Newingtons felt happy to restrict the attendants' role to one of personal service.⁶⁶

The emphasis on attendants as personal servants also makes it clear that, despite the renewed assertion of a strong moral authority over patients, the asylum was perceived as providing a service to patients and their

families in which the wishes of the asylum's clientele were sometimes the paramount consideration. In many ways, as the appointment of a French chef in 1893 confirmed, the prototype for the asylum continued to be that of a costly country hotel. Although attendants did not wear uniform, the domestic staff at Ticehurst, such as footmen, were dressed in livery. Smartness and neatness of dress were often listed in the Attendants Book as assets when the Newingtons were considering whether or not to employ someone. One letter of reference in 1882, from a person who had previously visited Ticehurst to see a patient, expressed the opinion that the would-be attendant, G.H.Brown, was 'hardly a sufficiently smart man for your place. He looks fairly strong - not very good-looking... He is not so presentable a man as the Attendant who was looking after Mr. Rolles when I was at Ticehurst'; and whilst Brown was given one month's trial at the asylum, he was not offered a permanent appointment, although it is unclear whether this was because he was not sufficiently well turned-out.⁶⁷ In 1888, when L.B.T. was first admitted to Ticehurst, she mistook the asylum for an hotel; and in order to characterise the kind of service which his grandfather had provided at Ticehurst Walter Newington explained that Hayes Newington tried to make the asylum as much like a good quality hotel as possible, given the constraints imposed by treatment.⁶⁸ Although the

Newingtons had persisted in their strict treatment of Georgina Dovrington until her husband removed her, in some cases they allowed relatives' and patients' wishes to influence treatment. Thus in 1884, when the wife of one anorexic patient William Carter, who weighed only 6st.11lb., asked that he should not be weighed for a time because she thought it worried him, the Newingtons agreed to stop weighing him; after three days, however, afraid that Carter's continuing visible loss of weight meant that he was taking advantage of walks in the grounds to make himself vomit, they began weighing him again.⁶⁹

Whilst this example would suggest that, as in Samuel Newington's time, Alexander and Hayes Newington were prepared to be respectful of relatives' feelings only in so far as they did not interfere with fundamental principles of treatment, in 1900 they told a meeting of the M.P.A. that one reason why medical treatment was not more active at Ticehurst was that 'at times refusal or resistance may force us to modify what seems most applicable'. Speaking to a meeting of the Association which was held at Ticehurst they emphasised that:⁷⁰

With regard to treatment, we depend mostly upon the exercise of common sense and the moral atmosphere that has been formed around us in the course of the long existence of the Institution... We obtain good results by attention to physical conditions and the exercise of moral suasion by ourselves and those who receive their cue from us.

Although they went on to give a more detailed description of some of the physical therapies which had been employed at Ticehurst, this summary in some ways mis-represented what had in fact been a period of increased medical intervention in the 1880s and 1890s which might have been even more active if it had not been for the need to give full consideration to the feelings of patients and their relatives.

As has already been mentioned, in the early 1880s-90s there was an increase in the number of patients who were given chemical sedatives. Although at Ticehurst this paralleled an increase in admissions who were described as suffering from 'mania', a similar, slightly earlier, increase described at the Retreat by Anne Digby, suggests that it may also have been part of a wider trend in late nineteenth-century psychiatric practice (see Tables 30 and 30.1). From the early 1880s fewer patients were listed in the Medical Visitation Book as being treated for 'debility', and increasing numbers were prescribed medication for 'excitement', 'restlessness' and 'insomnia'.⁷¹ Unlike at the Retreat, the main sedatives used at Ticehurst in the late 1870s-90s were not chloral hydrate and potassium bromide. Although both these were used, together with chloroform, valerian and other milder means of calming patients such as the continuing use of mustard baths, in contrast to long-standing practice at

Ticehurst morphia began to be freely used as a sedative, and hyoscyamine, a purer and more powerful extract from the hyoscyamus which Thomas Mayo had recommended, was used as a hypnotic.

In the 1880s the strength of sedation was clearly graduated to correspond to the degree of restlessness and violence manifested by the patient. In cases of hysteria and moral insanity, mild sedatives were prescribed, with tonics and cathartics if the patient was also debilitated or amenorrhoeic. Thus in April 1883 Mary Phipps, who had been diagnosed as suffering from 'moral insanity', supposed cause 'suppression of period', was prescribed a tonic of aloes and iron, a cathartic, magnesium sulphate, and potassium bromide, tincture of valerian and spirit of chloroform simultaneously as sedatives. In January 1882 Rachel Groom, diagnosis 'hysterical mania', supposed cause 'disappointment over marriage', was given an enema before being prescribed the sedatives potassium bromide, tincture of hyoscyamus, and chloroform; and when despite this she still had a restless night, she was given 'syrupi chloralis', morphia and chloroform to quieten her.⁷² In cases of acute mania, like that of Emma Osborne described above, supposed cause 'uterine hysteria', stronger sedatives and purgatives were given, the purgative being prescribed prophylactically to counteract morphia's known side-effect of constipation as

well as to cleanse and decongest the system. From the early 1890s however morphia and hyoscine were increasingly injected hypodermically, and the rapidity with which patients could thus be quietened made these drugs a highly attractive option, even in cases of hysteria. Thus in a paper on 'The Diagnosis of Hystero-Epilepsy from Status Epilepticus' published in the Lancet in 1898, Ticehurst's resident medical officer Wilfred Robert Kingdon, described the case of D.D., a young female hysteric in the asylum, who had slept for five hours after being injected with hyoscine hydrobromate. As Kingdon stressed, the drug's rapid action and effectiveness when hypodermically injected made it 'much less tedious than the old chloroform method' of sedation.⁷³

Understandably, at a time when the motives of private asylum proprietors were being looked at highly critically, chemical sedation seemed preferable to increased mechanical restraint, the use of which was closely monitored by the lunacy commissioners. Dissatisfaction with British psychiatry in the 1880s spread more widely than the attacks made on private asylums by the lunacy reform movement. Pressure on the rates from overcrowded county asylums wanting to expand at a time of economic depression, in the absence of impressive cure rates, led to scathing criticism in the

press. Within the medical profession, the bacteriological discoveries of the 1870s-90s made psychiatry seem relatively lacking in research sophistication and therapeutic resources. As Batty Tuke expressed it in 1889:⁷⁴

The public seeks in vain for any manifest indication that the speciality which professes the treatment of insanity has kept abreast in the onward march of medical science ... asylum physicians have failed to stay the progress of the disease by the exercise of their art, and have but partially succeeded in bringing their speciality within the pale of medical science.

Whilst a hereditarian understanding of the causation of insanity offered no new therapeutic directions, except the possibility of prevention through the early identification and prophylactic treatment of those most at risk, practising medical superintendents cast around for possible remedies, in the search for which they were ready to look to abandoned treatments of the past as well as to new methods suggested by scientific medicine.

In 1881 the observation that an acute intercurrent bodily illness sometimes seemed temporarily to relieve insane patients of their mental symptoms led G.H.Savage to observe that cases like that of a general paralytic patient who became well enough to go home after developing a large carbuncle on his neck 'make one review the old blistering and seton treatment, and cause doubts to cross one's mind whether with heroic treatment also

passed away valuable remedies for some dangerous diseases'.⁷⁵ Although Hayes Newington's initial experiment blistering Elizabeth Beeching's neck had proved unpromising, in the 1880s-90s counter-irritation was prescribed in cases of acute mania, and to inhibit masturbation. Thus in 1885 after a consultation with Henry Maudsley, Marmaduke Simpson was started on a regime of cold shower baths every night and morning in the hope of allaying his excitement. When little change had occurred in his condition a week later, his head was shaved and croton oil applied to blister his scalp.⁷⁶ In cases like this, the eruption of blisters was believed to be beneficial because it might relieve the blood of toxic materials which were thought to be causing the patient's symptoms. In the case of counter-irritation used to discourage masturbation however the rationale was rather that masturbation might be a reflex response to local irritation, which could be interrupted by providing an alternative, stronger source of irritation.

Speaking at a meeting of the M.P.A. in 1886 Hayes Newington opposed the idea put forward by Robert Percy Smith (1853-1941), quoting the American neurologist Edward Spitzka, that 'even the grossest lesions of the female genitary apparatus are not sufficient of themselves to produce insanity'. Spitzka had spearheaded the American Asylum Reform Movement in the late-1870s,

allying himself with critics of American medical superintendents like John Charles Bucknill, who also made vociferous criticisms of English private asylums; and Hayes Newington's knowledge of this fact might help account, one week before the second reading of a bill which would have completely abolished private asylums in England if it had become law, for the evident peevishness with which Hayes Newington observed that 'it was very hard that the uterus should be excepted when almost all other organs were allowed to have a share in producing insanity'. Certainly he had little cause to quarrel with Percy Smith, who as Savage's assistant medical officer at Bethlem (where Savage had succeeded Rhys Williams as resident physician in 1878), had so far published case-histories on two cases of moral insanity, one of which was described as a case of 'congenital moral imbecility', and two 'Cases of Temporary Improvement of Mental Symptoms co-existent with the Development of Local Inflammations'. Arguing in opposition to Spitzka that 'very small lesions in females often [cause] a very serious state of mind', Hayes Newington suggested that an irritation of the os uteri could produce 'a distinct class of mental alienation' in which menopausal women became compulsively obscene, and began to masturbate as 'a kind of counter-irritation to relieve the uterine trouble'. Although female patients who masturbated at Ticehurst were douched with alum to soothe any

irritation, the use of the blistering agent liquor epispasticus to discourage masturbation in male patients commenced after Hayes Newington's arrival at Ticehurst. The idea that masturbation in men could also be caused by local irritation was clear in the case-history of C.J., a chronic masturbator who was circumcised at Ticehurst in 1895 because it was believed that his 'prepuce ... was abnormally long & allowed secretion to collect, forming a source of irritation'. Although the percentage of female patients whose mental disorders were attributed to gynaecological and obstetrical problems on admission declined sharply after 1885, and never regained their former prominence, it is clear that Hayes Newington continued to believe, like Skae and Clouston, that 'the whole of insanity specially associated with the female sex was more or less connected with the sexual relations'; however, the rationale behind the belief that amenorrhoea could lead to mental disturbance was now toxæmic rather than hyperæmic, the fear being that an absence of periods meant that degenerated uterine tissues were retained within the body as a potential source of poisoning (see Tables 30.4 and 30.5).⁷⁷

The belief that toxins in the body could cause insanity was evident in Skae's interest in mental disorders due to alcohol and lead poisoning. In his 1873 paper on syphilis, Hayes Newington had referred to 'foreign

material', left behind after the acute syphilitic inflammation, causing the patient's symptoms. As G.H.Savage admitted in his presidential address to the M.P.A. in 1886, when it came to syphilis 'we know so little of its nature that it is more as a convenience that we call it a poison than from anything we know actually of its nature'; but under Savage's co-editorship the Journal of Mental Science published several articles on the value of counter-irritation in the treatment of general paralysis in particular.⁷⁸ Taking up the general point that mental disturbance could be caused by 'retention of abnormal material in the blood', in April 1887 Hayes Newington suggested to the M.P.A. that since one patient had improved mentally after an attack of haematuria, if his condition worsened 'it would perhaps be desirable to try the effect of bleeding him'. Although one year earlier a paper on the value of bleeding in epilepsy had met with some favourable comments at a Scottish meeting of the M.P.A., a revival of venesection ultimately posed more problems than therapeutic promise. In 1886 a Dr Pritchard Davies had noted in an article on the benefits of counter-irritation in the treatment of general paralysis that the only disadvantage to its use, even in a county asylum, was 'the conviction attendants and patients have that "blistering" in any form is but a punishment'.⁷⁹ Venesection was the example Alexander and Hayes Newington

gave as a case in point when they suggested that the 'resistance and refusal' of patients was a major obstacle to 'active' medical treatment, and no patients at Ticehurst were venesected after 1895, when an epileptic patient, Lt Col G., had twelve ounces of blood removed from his arm by Alexander Newington.⁸⁰

The belief that toxins could cause a reflex irritation or inflammation of the nervous system or brain also provided a rationale for the use of enemas rather than purgatives. Thus in 1900 Alexander and Hayes Newington argued that enemas were preferable to purgatives because they cleansed the bowel more thoroughly of any residual faeces, preventing it from '[producing] a reflex irritation, or perhaps even a more direct action on the nervous system by absorption into the blood of injurious faecal degeneratives'.⁸¹ Whilst it was indicative of the poverty of therapeutic resources available to late nineteenth-century psychiatrists that the heroic treatments of the late-eighteenth and early-nineteenth centuries should have been revived under a rationale of toxæmia rather than hyperæmia as the hypothesized cause of mental disorders, it is understandable why late-Victorian psychiatrists chose to look to a toxicological analysis of the blood for a new initiative in the treatment of insanity. In the late 1860s-80s morphological studies of the blood had helped lead to the

bacteriological breakthroughs of the germ theory, which in the 1890s yielded a rich prophylactic harvest of antitoxins for the prevention of physical disease through inoculation. If microscopic analysis had failed to fulfil Bucknill and Tuke's 1858 hope that it would make perceptible an organic pathology of the brain and nervous system which was imperceptible to the naked eye, in the late 1880s-90s chemical physiology seemed to offer an alternative route to a more sophisticated understanding of mental disorders which left no structural alteration of the brain and nervous system than their simple description as 'functional'.

Nor was this hope without some promise of fulfilment. Victor Horsley's (1857-1916) work on myxoedema in the late 1880s led to successful trials in the early 1890s of the use of thyroid extract in treating myxoedematous insanity. In 1895 Clouston read a paper to the annual meeting of the M.P.A., by one of his assistant physicians at Morningside L.C. Bruce, in which Bruce suggested that the effect of thyroid extract in raising body temperature and quickening the pulse might make it more generally useful in the treatment of insanity as a pyretic. As Clouston argued in one of the later editions of his Clinical Lectures on Mental Diseases the effects of thyroid secretion appeared to be similar in action to a toxin circulating in the blood, holding out the hope that

psychiatrists might:⁸²

some day be able to inoculate some septic poison and get a safe manageable counter-irritant and fever, and so get the alterative effect of such things and the reaction and stimulus to nutrition that follow febrile attacks.

If Julius Wagner-Jauregg's (1857-1940) use of malarial infection to halt the progress of general paralysis of the insane ultimately realised some of Clouston's hopes in 1917, Hayes Newington was almost certainly attracted to the use of thyroid extract for its alleged stimulative effect in cases of stupor rather than its potential as a fever-inducing agent. In the late 1890s thyroid extract was prescribed to two stuporous patients at Ticehurst with only temporary beneficial effects, and by 1900 Alexander and Hayes Newington were ready to conclude that 'no special benefit [arises] from thyroid treatment', despite continuing interest amongst other members of their profession.⁸³

Stuporous patients were also treated with electricity in an attempt to stimulate their nervous systems. Thus for example in 1897 D.D., the 'hysterical' patient who later developed epileptoid fits and whose case-history was published by W.R.Kingdon, had her spine massaged with a faradic current which was said to have produced a 'very considerable moral effect, and for a short time she is able to answer questions and appears much brighter'. In 1900 Alexander and Hayes Newington noted that

electro-magnetism helped convince some patients with 'globus hystericus' that they could open their throat and swallow, thus avoiding the necessity of force-feeding. One patient who was treated in this way was the anorexic William Carter, who was given regular electro-magnetic massages in 1883. The Newingtons also cited one exceptional recovery after a patient was galvanized, when thirty-eight year old Leon Lazarus, who had been subject to cataleptic fits since he was sixteen, became well enough to go home after being galvanized in 1883, and had remained well up until 1900.⁸⁴

After 1900 the principles of treatment applied by the Newingtons remained much the same as in the latter decades of the nineteenth century. As the proportion of patients described on admission as being in a state of mania declined, so too did the number of patients who were prescribed medication for 'excitement' and 'restlessness'. It is worth noting however that this decline in chemical sedation was nevertheless paralleled by an increase in the number of incidents of bruising and other minor injuries caused in struggles with attendants.⁸⁵ The reduction in the prescription of morphia, particularly in its hypodermic administration, may also have been influenced by growing concern over the drug's addictive properties. Early studies of the barbiturate veronal, introduced into the English market

by Fischer and von Mering in 1903, stressed its apparent non-addictiveness as one of the drug's advantages. Since the early 1890s synthetic narcotics like sulphonal, and later trional, had been used in preference to morphia in cases of chronic or recurrent mania. Initially veronal was tried at Ticehurst on patients of this type, since, being about twice as powerful as trional it could be administered in stronger doses without ill-effects. Thus in March 1904 J.B., a chronic maniac, was prescribed veronal during a period of excitement, rather than trional with which she had hitherto been sedated; however the veronal '[did] not have much effect', and when she next became excited she was again sedated with trional. Whilst published studies of veronal's prime effectiveness suggested it was best used as a narcotic in cases of hysteria and insomnia caused by melancholia, rather than as a sedative in cases of acute mania, the Newingtons conducted their own trials by substituting trional for veronal to see which was more effective. Thus in September 1904 when L.B.T., who had been diagnosed as suffering from 'hysterical insanity' in 1888, was re-admitted as a voluntary boarder she was prescribed veronal as a hypnotic, then trional, and then veronal again because the 'Trional did not seem to answer so well'.⁸⁶

However these medical experiments were fundamentally

concerned with the problem of how to manage troublesome patients rather than with therapeutic results. The insecurity of the 1880s had led to an increased heroicism in medical treatment, but the Newingtons' willingness to let their interventionism be curtailed by the opinion of patients and their relatives revealed the social pressures, and lack of deep therapeutic conviction, which had underlain this enhanced activity. As might be expected, the strong sedation of patients, and pervasive lack of therapeutic optimism, led to a gradual decline in the percentage of patients who were discharged 'recovered', which fell to an all-time low of around 15% of first admissions between 1895 and 1905, rising again to around 25% between 1905 and 1915, but remaining below the 'recovery' rates of the late 1850s-70s. Overall, the percentage of patients who were discharged 'recovered' and 'relieved' also declined, suggesting that this change did not simply reflect the Newingtons' perceptions of how much they were able to achieve (see Figures 9 and 11). Following the protection of existing private asylums under the lunacy act of 1890, pressure on psychiatrists to intervene more actively, whether or not they had therapeutic resources at their disposal, was reduced, and the increased security of their social position may be one reason why the Newingtons were not tenacious in pursuing the potential of new therapies, such as thyroid treatment. Apart from the introduction of barbiturates,

there were no new therapeutic developments at Ticehurst in the last seventeen years for which Hayes Newington was medical superintendent.

In 1917, Charles Mercier described Hayes Newington in an obituary in the British Medical Journal as having been:⁸⁷

... a Tory both in politics and in medicine. He would have said, like the late Duke of Cambridge that he was ready to welcome any innovation that was an improvement; but like the late Duke, he never considered an innovation an improvement.

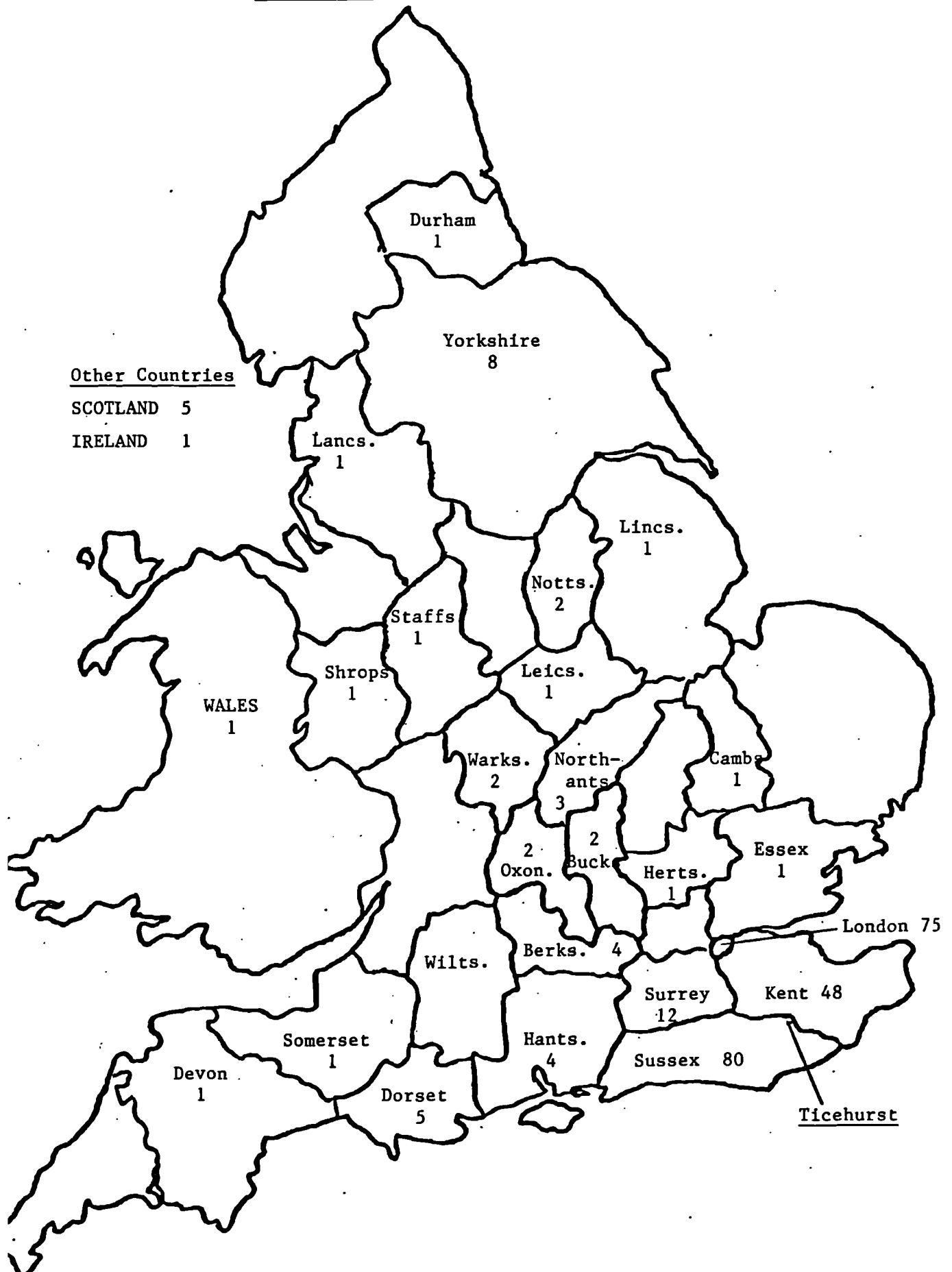
As this section has shown, there was a deeply reactionary thrust in Hayes Newington's treatment of patients at Ticehurst in the late nineteenth century. If Mercier's comment to some extent exaggerated Hayes Newington's unwillingness to try new forms of treatment, it captured the apparent lack of enthusiasm and persistence with which he carried out any experiments he made. However, Newington's ultimate faith in the potential of scientific medicine, and particularly the toxicological hypothesis, was demonstrated, in a manner which will be explored more fully in the next section, by his choice of Colin McDowall, who had done work on changes in the appearance of leucocytes in the blood of the insane, as his successor as medical superintendent at Ticehurst (see Appendix 2). In the next section, the extent to which Hayes Newingtons' responses to early twentieth-century debates on the classification of insanity and eugenics

reflected his political opinions will be explored, together with the strategies by which he continued to attract and keep patients at Ticehurst, despite declining rates of recovery.

iii) The Asylum and the Outside World

Although admissions remained fairly constant throughout the period 1885-1915, there are some indications that the decline in therapeutic optimism may have affected business. A decreasing percentage of admissions travelled from outside Sussex, Kent or London, and particularly from abroad, to become patients at Ticehurst (see Tables 28.1 and 28.3, and Figure 12). In 1885 Hayes Newington had complained that 'in the case of the wealthy it is well known that an asylum is generally the last thing thought of'; and although he advocated early treatment as offering the best chance of recovery, between 1895 and 1915, for the first time since 1845, the median age of first admissions rose from 35-44 to 45-54, suggesting that Ticehurst's clientele were becoming more, rather than less, reluctant to commit their relatives to private asylums (see Table 27). It is difficult to assess however how far the restriction on expansion of the private madhouse system in the 1890 lunacy act also affected admissions. As private asylum places filled with chronic cases, it seems likely that a queue for admissions would have formed, particularly at a

Figure 12: Place of Origin of First Admissions from within
the United Kingdom, 1885-1915



prestigious institution like Ticehurst. In Sussex and Kent in 1890 St George's, Periteau House, North Grove House, Springcroft, West Malling Place and Tattlebury House, still run by the Goudhurst branch of the Newington family, all remained open. By 1915 all except St George's, Periteau House and West Malling Place had closed; but the Harmers, who closed North Grove House, had opened a new asylum in Tunbridge Wells, called Redlands, and the McCartneys, who had taken over Tattlebury House from the Newingtons in 1903, ran Riverhead House in Sevenoaks, suggesting that demand had not fallen dramatically despite the opening of a new county asylum for East Sussex, with some space for private patients, at Hellingly in 1900. Nationally, a rise in the number of single patients confined at home or in single care reflected a short-fall of private beds, for the kind of clientele who were unwilling to accept treatment in the private wards of county asylums, but the fact that the majority of single patients continued to be women suggests that, as hitherto, those who could afford to pay for private asylum treatment were more willing to do so for a male breadwinner, and many probably hoped that a cure would result.⁸⁸

The class of patients admitted to Ticehurst remained high, with an increasing percentage coming from the plutocracy of the commercial and financial world, as well

as the professions, trade and manufacturing. It is noticeable however that a decreasing proportion of admissions to Ticehurst came from the medical profession, perhaps reflecting some decline of confidence in the Newingtons, if not in private psychiatric care as a whole (see Table 29.1). Locally, a small number of doctors continued to certify a disproportionate number of admissions. Thus Augustus Woodroffe, who had succeeded John Taylor as medical officer of Ticehurst Union certified 26 admissions between 1885 and 1917, and Charles Herbert Fazan, who followed William Mercer as medical officer of the Wadhurst District of the Ticehurst Union, signed certificates for 19 admissions in the same period, making it clear that some patients were still brought to Ticehurst to be certified, rather than arriving with certificates. In London, apart from G.H.Savage's 27 admissions, the most frequent signator of certificates was Robert Percy Smith, who succeeded Savage as resident physician of Bethlem in 1888, and certified 17 admissions to Ticehurst before 31 July 1917.⁸⁹ Most patients continued to be confined on the authority of a close male relative (see Table 34).

Yet if the difficulty of caring for an insane person at home, and the lack of alternative provision, meant that, however despairing some relatives may have been of a cure, patients continued to be referred to Ticehurst, in

the early 1880s the threat of closure, or irreparable damage to the public image of private asylums, was real. Although Hayes Newington had shown some ambition and willingness to become involved in committee work through his appointment to the statistical committee of the M.P.A. in 1876, and the council of the M.P.A. in 1882, it was opposition to the lunacy reform movement which carried him onto the parliamentary committee created to review the proposed lunacy legislation in 1884. For the next thirty-three years he was one of the Association's most active members, being appointed auditor in 1885; president in 1889-90; a member of the education committee in 1889; and treasurer in 1894, in addition to remaining on the statistical and parliamentary committees. A regular attender of annual and quarterly meetings, as well as these committees, Hayes Newington was willing to travel as far as Cardiff, Cork, Dublin, Edinburgh, Glasgow, Liverpool, Manchester, Newcastle-on-Tyne and York for meetings of the Association. If his clinical pre-occupations of the 1870s were replaced by an interest in the more managerial problems of prognosis and discharge in the 1880s, after 1887 he became exclusively concerned with problems of administration; his enjoyment of general, as well as professional, politics was evident in his election to Sussex County Council in 1888, the vice-presidency of the B.M.A.'s psychology section in 1898, and the B.M.A.'s Medico-Political Committee on 'the

amendment of the law with regard to the treatment and detention of cases of incipient insanity, inebriety, and the drug habit' in 1900.⁹⁰ Since the lunacy act in 1890 restricted free competition between private asylums; and, more importantly, because for reasons of confidentiality a full description of the social context surrounding referral and certification in this period would be inappropriate, this section will concentrate primarily on Hayes Newington's professional career, and the fortunes of the M.P.A., as one way in which he strove to ensure Ticehurst's future, and one index of how successful he was.

In the early - mid 1880s the insecurity of psychiatrists vis-à-vis the rest of the medical profession, as well as the general public, led several prominent medical psychologists to consider the question of how psychiatry related to general medicine. In 1884 Savage's initial tentative distinction between 'functional disorders' and 'organic diseases' was made in a presidential address to the psychology section of the B.M.A. which, whilst it lambasted aetiological psychiatric nosologies for confusing a description of symptoms with an understanding of mental diseases and disorders, called for more physiological measurements of the insane to be routinely taken in asylums in the hope of discerning a new physical pathology; more importantly, he argued for an expansion

of the importance of psychological medicine to the profession as a whole, through an exploration of the mental symptoms of ordinary physical disorders. Two years later, Clouston's presidential address to the same section raised the question 'How may the medical spirit be best maintained in our asylums?', and suggested that the separation of acute and chronic cases, with more active treatment of the former in a hospital wing, would help re-assert the medical and curative, rather than custodial, nature of asylums.⁹¹ Although the proposed legislation of 1886 was dropped, a new bill was being drafted in 1887-8, and the medical respectability of psychiatry continued to be a central concern of those who hoped psychiatrists' powers would be protected, rather than curtailed, in the new lunacy act.

How could such respectability best be assured? In February 1888, a storm of protest was raised in the M.P.A. over the appointment of a Dr C.E.Saunders, who had no experience of psychiatry or asylum management, to the medical superintendency of Sussex County Asylum. Under rules drawn up in 1870 the Sussex medical superintendency had to go to someone who was a graduate of a British university, and a member of one of the two British colleges of physicians. Unable to find a suitably qualified candidate amongst those with experience of asylum work who applied for the post, the Sussex

committee of visitors appointed Dr Saunders instead.

However as Dr Murray Lindsay, the medical superintendent of Derbyshire County Asylum, pointed out to the M.P.A.:⁹²

Out of a total of 54 superintendents in 52 county asylums, only nine ... are medically qualified and eligible according to the Sussex rule... Out of a total of 12 borough asylum superintendents, only three ... are medically qualified and eligible... the three Senior Medical Commissioners in Lunacy for England, Scotland, and Ireland, one of the Lord Chancellor's Visitors in Lunacy, and half the Council of the Medico-Psychological Association, are all medically unqualified and ineligible.

Psychiatry in the late-1880s was thus a fairly low-status branch of the medical profession as a whole; the only prior qualifications required to sit the M.P.A.'s certificate in psychological medicine - not, in any case, a pre-requisite for asylum appointments - were that candidates should be medically licensed, and have some experience of working in an asylum. At the next annual meeting of the Association G.H.Savage proposed a resolution that the Medical Council should be asked to register the M.P.C., 'and that the importance of this guarantee of practical experience of lunacy be impressed upon the Government in introducing any new Lunacy Bill', a motion which was unanimously carried.⁹³ Yet as Murray Lindsay may have been aware, one sector of psychiatric practice already included a majority of university graduate M.R.C.P.s: thirteen of the twenty-four medical proprietors of metropolitan licensed houses had both

these qualifications, including those like Henry Monro, Henry Sutherland, Henry Forbes Winslow and William Wood, who were direct descendants of the pre-Association network of private asylum proprietors.⁹⁴

Whilst the new lunacy bill was being drafted in 1887-8, some county asylum superintendents complained that the M.P.A.'s parliamentary committee, formed to lobby against the 1886 bill, was mainly composed of psychiatrists who worked in the private sector. Apart from Hayes Newington, five members of the committee of fourteen had links with metropolitan licensed houses, including William Wood; one was joint-proprietor of Fisherton House in Salisbury; three were medical superintendents of registered hospitals, including Frederick Needham from high-class Barnwood in Gloucestershire and G.H.Savage from Bethlem; leaving only four members of the committee who worked in the public sector: T.S.Clouston, and three other district and county asylum superintendents, from Ireland, Northumberland and Lancashire respectively. Of prime concern to county asylum superintendents was the fact that the parliamentary committee had failed to persuade Salisbury's government to include pensions for former county asylum superintendents amongst statutory requirements to be provided by the new county councils created by the local government act; and that so far the new lunacy bill's only recommendation concerning pensions

was that any pension rights included in county asylum medical officers' contracts of service should be transferable within one county. The parliamentary committee's published recommendations for amendments to the new bill - opposing a clause which would have prevented medical practitioners from receiving single patients, insisting that chancery patients ought to be able to be sent on temporary leave from asylums like other patients, and criticising compulsory questions on admission concerning 'whether any near relative has been afflicted with insanity' - primarily reflected the concerns of private asylum proprietors, although they also recommended that county asylum superintendents' pensions should be transferable from one county to another, as well as within one county. Few county-asylum members of the Association can have been pleased, therefore, when they arrived at the annual meeting in Edinburgh in August 1888 to learn that, at a time when new negotiations seemed possible because the lunacy bill had been postponed to the next parliamentary session, the M.P.A.'s council were recommending Hayes Newington to succeed Clouston as president of the Association in 1889-90.⁹⁵ The selection of a university-educated, although not graduate, M.R.C.P. from one of the oldest families of private asylum proprietors in the country represented all the vested gentlemanly interests the insecurely professionalized county asylum superintendents

felt they needed to oppose.

Although Hayes Newington's selection was not openly contested, several members of the M.P.A. raised objections to the system of election under which the council recommended nominees who were then invariably approved by the full membership of the Association. Ordinary members had the right to propose alternative nominees, but in August 1888 David Yellowlees, from Gartnavel Asylum in Glasgow, described the electoral procedure as a 'solemn farce, since no one would think of erasing any of the names proposed by the Council'.⁹⁶ Clouston pre-empted any immediate alteration in the system of election by appealing to the rules of the Association, which stated that advance notice had to be given to members of motions which were to be discussed at the annual meeting, and suggested that Yellowlees should propose a different electoral system at next year's meeting. A motion proposed by the medical superintendent of Hanwell, Dr Henry Rayner, that the ordinary membership of the council of the Association should be increased from 12 to 18, making a total of 28 council members including those who held special offices, was unanimously carried. Amongst those who spoke in favour of this motion was Alexander Urquhart, a former assistant medical officer at Ticehurst under Hayes Newington and now physician superintendent at Perth Royal Asylum, and the

Association's Scottish secretary; Urquhart complained that since quarterly and committee meetings were held in London and the Association could not afford to refund travelling expenses, 'it was thought by some in the country that London influence predominated too much in regard to the business and the selection of officers', a fault which he hoped the councils' increase in size would help to correct. At the same time as Hayes Newington was elected president, ten new members, four of whom replaced retiring councillors, were voted onto the council, including nine who were superintendents of county, borough or district asylums.

In addition, after further discussion of members' concern that county asylum superintendents were under-represented on the parliamentary committee at a time when the re-structuring of local government might lead to major financial problems as rate-bound elected representatives replaced county magistrates on the committees of visitors, Henry Rayner proposed a second motion that the parliamentary committee should be empowered to draft in more members, in the hope of securing a fuller representation of county asylum superintendents' views; and this was also approved.⁹⁷ When news of the death of John Alfred Lush, joint-proprietor of Fisherton House through his marriage to W.C.Finch's daughter, and a former Liberal M.P. for Salisbury in 1868-80, reached the

parliamentary committee, they did appoint a district asylum superintendent, Dr T.Oscar Woods, onto the committee; but it seems unlikely that he would have travelled all the way from Co.Kerry in Ireland to attend committee meetings in London. No other county asylum superintendents were drafted onto the parliamentary committee, and the new lunacy legislation, which incorporated some of the M.P.A.'s suggested amendments, but made no change to the bill's original clause on county asylum superintendents' pensions, was safely on the statute books before the parliamentary committee could be radically re-structured at the next annual meeting of the Association in July 1889. Speaking at this meeting in favour of a new parliamentary committee, a Dr T.Outterson Wood commented that it might be advisable in future to keep a record of attendances at committee meetings, since 'some of these gentlemen [i.e. the existing parliamentary committee] have attended no meetings at all'; T.Oscar Woods was not amongst the nine county, borough and district asylum superintendents appointed to the new parliamentary committee alongside seven medical superintendents or visiting physicians of private licensed houses, one medical superintendent of a registered hospital, and G.H.Savage, who had resigned as physician superintendent of Bethlem, and now worked as a private consultant in London.⁹⁸

It is unclear how far the death of Dr Lush, who had sat on the select committee of 1877, and, as his obituary in the Journal of Mental Science expressed it, retained 'his loyalty to the ex-Premier' Gladstone, helped ease negotiations with Salisbury's government, but after the bill's second reading in the House of Commons in June 1889 it was referred to the Standing Committee on Law, who agreed to incorporate some of the M.P.A. parliamentary committee's suggested amendments. By refusing to press the question of the security of county asylum superintendents' pensions, focus was brought to bear on the restrictions the bill would have imposed on private practice and important concessions were gained, particularly when the Standing Committee reversed the bill's prohibition on medical practitioners' receiving single patients into their own homes. Although new licences for private asylums would be issued only in exceptional circumstances, the lunacy act permitted medical practitioners to receive single patients into their homes, and included the amendment that 'Under special circumstances the Commissioners may allow more than one patient to be received as single patients into the same unlicensed house'.⁹⁹ With undisguised pleasure, but some disingenuity concerning their own role as members of the M.P.A.'s parliamentary committee in helping to secure this change, Savage and Hack Tuke suggested in their 'Occasional Notes of the Quarter' in

the Journal of Mental Science that:¹⁰⁰

It is not a little amusing, and is surely the very irony of fate, that a Bill brought in with the avowed purpose of abolishing Private Asylums should deliberately introduce a clause, at the last moment, and under no pressure whatever from without, which restores Private Asylums to all intents and purposes, without a license, and more important still, without the supervisory visitation required in the case of Licensed Houses.

On the one hand, restrictions on the issuing of new licences legally underwrote the cartel of private practitioners which had to some extent remained unchanged since the early-1840s, at a time when the crisis in British psychiatry threatened their future survival, ensuring that as private asylums filled with chronic cases, demand from consumers would always exceed the number of places available. In this sense the lunacy act represents an early example of late-Victorian Conservatives' increasingly protectionist economic policies during a period of economic decline, which led in the 1890s to the levelling of high tariffs on imports under the slogan of 'fair trade' rather than 'free trade'; one of the M.P.A. parliamentary committee's criticisms of the lunacy bill as it was originally drafted was that, if medical practitioners were not allowed to take in private patients in Britain, the relatives of upper and middle-class lunatics would simply send them abroad.¹⁰¹ On the other hand, the twilight area of 'special circumstances' under which more than one

patient could be received into unlicensed houses also left room for expansion in a less strictly regulated market if demand rose to a sufficiently high level. Care in an unlicensed house still offered the greatest privacy to patients' relatives; although even when a patient was admitted into single care two medical certificates were required, and one amendment which the M.P.A.'s parliamentary committee had failed to secure was Hayes Newington's recommendation that there should be no question on the admission papers concerning any insanity amongst the patients' close relations.¹⁰² The revised bill did incorporate the M.P.A. parliamentary committee's proposal that chancery patients should be allowed to go on trial discharge as other patients were; and although the Commons re-inserted a clause which the Standing Committee had thrown out, that patients' rights should be displayed on the walls of private asylums, Savage and Hack Tuke were confident that, since whether or not they were displayed depended on the direction of the lunacy commissioners, 'The impotence of this clause is apparent when it is well known that the Commissioners do not think any such proceeding in asylums called for'.¹⁰³

One clause which was first introduced into the lunacy bill after the M.P.A. parliamentary committee's proposed amendments had been published in July 1887 was section 45, which stressed that 'Mechanical means of bodily

restraint shall not be applied except for surgical or medical treatment, and to prevent the lunatic from injuring himself or others'.¹⁰⁴ This amendment may have been included partly as a result of a series of letters to the Times in September and October 1888, which alleged that an excessive use of mechanical restraint and strong sedation at Bethlem had resulted in an unusually high death-rate of 14.4% (as opposed to 7.8% of asylum inmates nationally), and that in June 1887 18 out of 264 patients had been mechanically restrained at Bethlem, compared to a total of 25 cases of mechanical restraint recorded in all other asylums in Britain during the same month. Despite publically defending his use of restraint in the columns of the Lancet, but not the Times, Savage resigned as resident physician at Bethlem. However, the psychiatric profession as a whole closed ranks, holding a testimonial dinner at the Cafe Royal on 2 November to mark Savage's retirement, to which his former associates at Bethlem, presumably including Alexander and Theodore Newington, were invited.¹⁰⁵ On 8 November, at the Scottish quarterly meeting of the M.P.A., David Yellowlees read a paper on 'The Use of Restraint in the Care of the Insane' which defended Savage's position, pointing out amongst other things that the fact that the Scottish lunacy commissioners did not count the use of gloves as mechanical restraint meant that ten out of Savage's eighteen cases of restraint in June 1887 would

not have been counted in Scotland. Most subsequent speakers concurred that a limited use of instrumental restraint was an indispensable part of their resources as asylum physicians. A Dr W.W.Ireland stated bluntly that 'the present generation was wanting in nerve, and shrunk from employing some remedies which proved useful in some cases... - such as blood-letting, the use of antimony and mercury'. But Clouston responded to the feeling of the meeting when he suggested that criticism of Savage's practice had mainly come from older members of the profession, like John Charles Bucknill, and that:

... he [Clouston] thought they had passed into a different era from that in which those gentlemen had been trained. They had passed into a more scientific era, and were free from the passions and prejudices of Conolly's great struggle, and, whilst sympathising with their philanthropic views, he thought their medical ideas to a large extent wanting in courage and scientific basis ... In some exceptional cases ... restraint was the only remedy, the most humane resource, and the most scientific application of the principles of modern brain therapeutics.

Clouston also warned however that mechanical restraint should be used with caution, since 'The beginning of it, like whisky on some people, tended to make them crave for more'.¹⁰⁶

Whilst section 45 was clearly intended to clarify the limits of what the lunacy commissioners would regard as a reasonable use of mechanical restraint in a restrictive way, it inscribed in law the original belief of members

of the 1840s Society for Improving the Condition of the Insane that some use of instrumental restraint was both necessary and valuable. Savage and Hack Tuke initially criticised the introduction of this clause as an 'interference with the action of the medical superintendent', but by the time the bill became law they were hailing it as:¹⁰⁷

the first time in the history of lunacy, mechanical restraint has been formally recognised by an Act of Parliament. The medical superintendents of asylums will now have legal authority for applying 'instruments and appliances' in the treatment of patients without the doubts and misgivings they have long suffered from as to whether mechanical restraint is or is not a legitimate form of treatment.

Although they allowed a debate to take place in the Journal of Mental Science between Alexander Robertson, physician of Glasgow City Parochial Asylum, and David Yellowlees, whom Robertson accused of being 'the leader in Scotland of ... a distinctly retrograde movement', Savage and Hack Tuke also encouraged a broad interpretation of the act's meaning, suggesting for example that patients who continually removed their clothes, but were not suicidal or dangerous, ought to be restrained 'for to clothe such lunatic and keep him warm is certainly medical treatment, and prevents him injuring himself by bringing on fatal pneumonia through exposure'.¹⁰⁸ It seems important to emphasise however that in cases like this the use of strong clothing, rather than a complete restriction of physical movement,

was what was being recommended. Further research would be needed to establish whether an extensive increase in mechanical restraint followed the 1890 lunacy act: certainly at Ticehurst there was no increase in its use. Nevertheless, like the proposed return to blood-letting, and increased use of counter-irritation, the advocacy of a greater use of mechanical restraint reflected the therapeutic and managerial despair of asylum superintendents whose medical philosophy gave them little reason to hope for any improvement in recovery rates, who were becoming wary of the extensive use of strong narcotics as 'chemical restraint', and who felt unsupported by local and national governments' refusal to provide substantial financial incentives for medical practitioners who worked in asylums. The advantages of sulphonal over other sedative drugs were as enthusiastically discussed at these meetings as the use of mechanical restraint.¹⁰⁹

When Hayes Newington took over the presidency of the M.P.A. in July 1889 his own future had been made relatively secure by the new lunacy act, but he faced a profession whose financial security was less certain, and who felt their interests had been poorly represented by the Association's parliamentary committee. A new bill introduced into the Commons shortly before the lunacy act had been passed, dealing with 'County Councils

Superannuation of Officers' recommended that pensions should be derived from deductions of two and a half per cent from officers' salaries and wages, which would not be matched by any money from the rates, nor make any allowance for the board and lodgings included in asylum officers' contracts of service, which made salaries proportionately lower; in addition, the bill recommended a voluntary retirement age of 65, which most members felt was too late. It was to Hayes Newington's advantage that at a meeting of the M.P.A. in June he had been able to assure members that in his capacity as a county councillor he had already successfully opposed one resolution put to Sussex County Council that county officials should be placed on contracts of service which included no pension rights whatsoever. Frederick Needham stole some of the county asylum superintendents' thunder by suggesting early in the meeting that the number of attendances M.P.A. councillors made during the year should be listed on the ballot paper when names came up for re-selection: clearly public asylum superintendents found it more difficult to create time to attend meetings, and although Alexander Urquhart reminded members that 'In order to broaden the base of the Council as much as possible, members [had] been placed upon it who had to come very long distances to attend the meetings', Needham's resolution, with its suggestion that some of the Association's representatives were not

pulling their weight, was carried. In addition, the parliamentary committee was re-constituted to include an equal number of county asylum, and private and registered hospital, superintendents, as was described above; and they were instructed to direct their immediate attention to the superannuation bill. Perhaps partly aided by his outspoken defence of G.H.Savage, David Yellowlees was chosen as president-elect; T.Outterson Wood's recommendation that the year members had joined the Association should be entered next to their names in the membership lists because 'The Council have great difficulty at times in arriving at the seniority of members when wishing to advance them in office', suggests that some of the Association attributed Yellowlees' attack on the M.P.A.'s electoral system to pique at having been overtaken by a man who had joined the Association eleven years after him. Placed in the invidious position of criticising the lack of democracy in a system which had just elected him future president, Yellowlees understandably proposed his motion that the electoral system should be changed with less than full conviction, and allowed himself to be talked out of putting the question to a vote.¹¹⁰ Yet if Hayes Newington had been able to mollify critics of the Association's true representativeness at the morning's meeting, it was important that his presidential address should inspire future confidence in his capacity to

provide sympathetic leadership to the M.P.A..

Unlike Savage and Clouston, who in their addresses as presidents of the M.P.A. had spoken on the pathology of insanity, but echoing Clouston's address as president of the psychology section of the B.M.A., Hayes Newington chose to speak to the Association on 'Hospital Treatment for Recent and Curable Cases of Insanity'. As the title suggests, he elaborated Clouston's idea of creating a hospital within an asylum to treat curable new admissions; and also argued for the establishment of new educational hospitals to raise the standard of clinical teaching within the profession. In several respects, Hayes Newington's paper addressed the contemporary anxieties of members of the psychiatric profession in Britain. He stressed that their cure rates were as good as those of general hospitals, asking whether:¹¹¹

anyone [would] be bold enough to say that doctors could make any radical reduction in the accumulation of the cemetery by finding out and following fresh lines of treatment? ... what would be the impression left on the public mind if the non-successful cases had, as with [psychiatrists], to be detained in general hospitals for reasons in no way connected with medical science?

he emphasised that, even where visiting or general physicians were consulted, the ultimate authority to decide, for example, whether a patient should be allowed on trial discharge, should rest with the resident medical superintendent; and he suggested that the

superintendent's 'stipend should be ample'. Whilst soothing the psychiatrists' self-doubts, and feelings that their work lacked recognition, he was also addressing contemporary newspaper debates on the possibility of establishing separate hospitals for curable cases of insanity, which it was proposed should be staffed by other medical specialists, such as gynaecologists, as well as psychiatrists. The L.C.C. had recently established a committee to investigate the potential benefits of building such a hospital.¹¹²

Within this framework, Hayes Newington also dealt with questions on the pathology of insanity, citing Skae's work as an early attempt 'to apply the science already belonging to the general profession to the stock of special knowledge ... then in the possession of alienists', and arguing, implicitly although not explicitly against Savage, that 'every endeavour should be made to connect general mental and special bodily abnormalities'.¹¹³ Whilst he conceded that 'as the demands of ... [mental] disease ... are urgent ... we have formed theories in default of exact information', he denied 'that our treatment is so lacking a foundation of reason that it deserves the epithet of empiric'. It was just over seventy years since Thomas Mayo had gone into print 'To vindicate the rights of [his] profession over Insanity', but Hayes Newington now felt a need to

re-emphasise the 'fact that we all admit, nay, that we are all fighting for, which is that insanity is primarily and essentially an expression of disease of the body'.¹¹⁴ Stressing the importance of further research he recommended that, in the educational hospitals he hoped to see created, a general physician and a neurologist, as well as several alienists, should be included on the staff, making it clear however that the 'non-alienistic' physicians would be subordinate to the resident superintendent. In addition, he suggested that the extension of voluntary boarding to pauper asylums would go some way to mitigate the stigma of certification, and encourage early referral.¹¹⁵ Since 1862, former patients had been allowed to stay on as voluntary boarders in private asylums; and the new act of 1890 extended this to allow new patients to be admitted voluntarily for treatment, so long as they were not suicidal or violent. During the first twenty-five years of the act's operation at Ticehurst however, most voluntary boarders were former inmates or re-admissions, rather than new referrals (see Table 35).

Yet if, with the lunacy act so recently on the statute books, Hayes Newington could already see room for improvement, the M.P.A. entered a less turbulent period under his presidency. Although attempts to register the M.P.C. as a recognised qualification failed, and the

lunacy act made no recommendation concerning its desirability as a credential when making asylum appointments, the passing of the act meant that public interest in the treatment of the insane abated, or became re-directed into local hospital plans. Under Hayes Newington's chairmanship a nursing committee was appointed to consider the possibility of introducing a professional examination for attendants on the insane, since the poor public image of county asylums was partly believed to be due to the poor quality of staff, and the unprofessionalized nature of asylum attendants was one way in which asylums could now be compared unfavourably with general hospitals.¹¹⁶ Since the appointment of attendants was the responsibility of the medical superintendent, this was also one area over which members of the Association could hope to exert considerable direct control; and by the next annual meeting, in July 1890, plans for bi-annual examinations of proficiency in mental nursing had been drawn up, to be based on teaching by medical superintendents in asylums, using the Association's Handbook as a text-book.¹¹⁷ When the L.C.C.'s investigation into the desirability of building a hospital for curable cases of insanity decided against recommending that such a hospital should be built, the M.P.A. established a committee to draw up their own recommendations of what shape future asylums and hospitals should take, and most members spoke

enthusiastically of the kind of blue-print Hayes Newington had proposed.¹¹⁸

The building of a county asylum for East Sussex at Hellingly in the early 1900s gave Hayes Newington, who sat on the county council's asylum committee, an opportunity to realise some of these plans in an institution which separated the 'curable' from the 'incurable' in an eighty-bed hospital. No provision was made in this hospital for very noisy or excited patients, who would instead be removed to the main building, since 'a temporary removal there, or a threat thereof, may have a salutary disciplinary effect'; however, perhaps uniquely in a county asylum, single sitting-rooms were included in the design - 'an idea, or perhaps a fad, of [Hayes Newington's]' - because the 'separation of highly excitable cases has a beneficial effect on excitement'. One way in which Hellingly differed from the asylum Hayes Newington outlined in his presidential address was that it included a separate house for sixty idiots, with accommodation for fifteen adult female chronics 'whose services will be required for ward cleaning; and it is hoped that we shall find some motherly bodies in the asylum who will take an interest in the children'. There was also a schoolroom in this building, since 'even if the children sat at the desks with their books upside down they were learning important lessons in sitting

still and general discipline'. In other respects Hellingly owed as much to Hayes Newington's experience at Ticehurst as to the extensive visits to other county and district asylums made by the asylum committee. Apart from the single sitting-rooms in the hospital, Hellingly was divided between a main building with 840 beds, and several detached villas. The former housing 'that considerable mass of patients who cannot appreciate anything more than warmth, good food, and adequate personal attendance', and including an infirmary for 300 patients, as well as accommodation for the acutely excited and suicidal; and the latter being lived in by chronic inmates who were able to work for the institution, who were given:¹¹⁹

More variety of food and more elasticity of régime ... These will make the houses more comfortable and less institutional, thus affording an inducement to patients to get to and remain in them ... Such a contrast in treatment between workers and drones is demanded by justice.

This plan clearly incorporated principles of moral management rather than moral therapy, since none of these patients were expected to ever recover; and Hayes Newington's economic analysis of the distribution of resources within Hellingly made it clear that any surplus numbers of staff or money would be invested in the hospital rather than in the care of chronic patients.

Although Hayes Newington hoped:

that the existence of such a half-way house, founded on the idea of active

hospital treatment, will overcome to a considerable extent the reluctance on the part of friends to send patients in the earlier days of the disease,

the Hellingly plan did not include an out-patients' department such as Hayes Newington had advocated in his presidential address as one means of spotting and treating early symptoms of mental disorder in the community, particularly amongst ex-patients.¹²⁰

Yet if at the turn of the century those asylums which were newly built or extended acquired the infrastructure of a more scientific medicine, this was not matched by any new understanding of mental disorders or disease. Clouston had demurred in the discussion following Hayes Newington's presidential address that:¹²¹

we shall not only need hospitals, but also a plentiful supply along with the hospitals of great and original minds, who are able to deal with this the greatest problem of medicine, the relationship of mind with brain.

Few psychiatrists were hopeful that, even with more talented practitioners, the development of a detailed physical pathology of insanity would be easy; or, necessarily, lead to therapeutic advance. As Savage expressed it in 1891:¹²²

If insanity is ... the definite result of primary changes in the nervous tissues, and if these changes are the common result of hereditary nervous irritability, then we are very helpless as physicians ... The time may come when medication will alleviate symptoms, but I fear will do little more for such cases.

This was why Savage chose to emphasise the 'functional disorders', which might not be amenable to medical rather than moral treatment, but were at least potentially curable. At a time of rapid therapeutic development in other areas of medicine, most notably immunology, psychiatry had little therapeutic promise, or professional prestige and security, to offer talented young medical students.

In 1888 Savage had encouraged medical officers in asylums to take the M.P.C. because 'It was a practical examination, and no one need fear it who had done his work well and kept his eyes open', but the fact that it was not a state-registered or required qualification meant that few asylum doctors sat the examination. By July 1901 the M.P.A.'s educational committee were pleased with the numbers of asylum attendants who took the nursing examination, but Clouston regretted that 'The Certificate of Psychological Medicine has been diminishing year by year'. In 1901-2 only two students passed the examination, although it is unclear whether any took it and failed. Psychiatrists had no reason to feel that their career prospects would be enhanced by taking it; and T.B.Hyslop, who had succeeded Percy Smith as resident physician at Bethlem, and was an M.P.C., suggested that the certificate was mainly perceived as the kind of practical and administrative examination

which would enhance medical practitioners' chances of gaining a job in the colonies or prison service, rather than a worthwhile professional qualification for those who wanted to work in psychiatry. The three-hour written examination, in which candidates were expected to answer four out of six questions, covered lunacy legislation as well as the diagnosis, pathology and treatment of mental disorders, and as Savage had argued stressed the practicalities of treatment, such as, for example, when it was advisable to start force-feeding a patient. Although candidates were expected to show a knowledge of clinical phenomena, there was no practical clinical examination.¹²³

The lack of a common training, or intellectual consensus amongst psychiatrists, and of a workable pathological schema, came to the forefront of debates in the M.P.A. in 1904-5 when the statistical committee, of which Hayes Newington was still a member, presented a table classifying diagnoses to the Association, which it was hoped could be recommended to the lunacy commissioners as a format which most psychiatrists would find it possible to work within. Apart from its emphasis on the importance of distinguishing between congenital and acquired disorders, this nosology in many respects resembled that adopted by the commissioners in 1844, and bore little relation to Skae's system of classification.

Although the report was provisionally accepted concern that the table revealed, as Yellowlees candidly admitted, that 'It is not a scientific system of classification', led to a separate committee being appointed to review this list of diagnoses. Hayes Newington, who rarely spoke at the Association on clinical questions, although he was a keen contributor to debates on legislation and administration, was not a member of this committee of nine, which was chaired by Percy Smith, and included Savage and Charles Mercier.¹²⁴

The classification committee met five times during the next year, including one meeting which lasted for six hours, whilst they strove, as Percy Smith expressed it, to reach 'a judicious compromise between conflicting views'. The most central argument was between those who favoured an aetiological classification and those who, influenced by recent developments in German psychiatry, wanted to concentrate on the clinical course of mental disorders as a basis for diagnosis. Although Savage had suggested in 1884 that 'The time is not far distant when the terms mania, melancholia, and dementia, will be merely used as are the words headache, vomiting and albuminuria, referring to symptoms and not to diseases', the system of classification proposed in 1906, which was slightly longer and more complex than that put forward in 1905, retained mania, melancholia and dementia as major

divisions, and specifically ruled out the inclusion of Kraepelin's new diagnoses of 'dementia praecox' and 'manic-depressive insanity', which they believed, for reasons which were unspecified, 'would not be acceptable to the Association'; in addition, they eschewed a diagnosis of 'paranoia' rather than 'delusional insanity'. The compromise they struck between the aetiological and clinical approaches was to focus on presenting symptoms, so that 'a person who found an insane man in the street, or who had an insane person produced to him without any history at all, could find a place in that suggested classification in which to put it' (sic); and the committee's report was accepted by 'a large majority'.¹²⁵ One anomaly to this approach, which nevertheless remained in the table after the M.P.A.'s discussion, was the diagnosis of 'alternating insanity' rather than manic-depression; and many of the discussants were confused about how they were to distinguish 'primary dementia', probably included as an alternative to 'dementia praecox', but historically exchangeable in British psychiatry with the diagnosis of 'stupor', which was also separately listed.¹²⁶ Although these diagnostic categories did not correspond to Skae's system of classification, overall the statistical committee's report favoured an aetiological approach, and the 'supposed causes' formerly listed in admission books were described in books printed after 1907 as 'aetiological

factors', divided as Clouston recommended between those which were 'principal' and those which were only 'contributory'.¹²⁷

The opposition to continental terminology was xenophobic rather than specifically anti-German; and, as the British Empire fell into increasing difficulties at home and abroad, was fuelled by the fear that the young were too insufficiently patriotic to want to defend their country. In a paper which was published amidst the mounting pre-war fever in 1912, Charles Mercier criticised the diagnosis of 'dementia praecox' as having 'all the definiteness of outline and architectonic precision of a par-boiled batter pudding', and accused:¹²⁸

the younger alienists in this country - the country of the Tukes and of Conolly, of Locke and Berkeley and Hume, of Hughlings-Jackson and Clouston and Savage - [of being] so bitten with the anti-patriotic bias, that they can see no merit in the most momentous discoveries of their own countrymen.

At Ticehurst the residential medical officer Charles Bell certified two patients as suffering from 'dementia praecox' in 1910 and 1913, one with the 'supposed cause' given as 'masturbation', and the other as 'puberty'. But in 1916, when due to the war Hayes Newington was temporarily responsible for keeping the admission books, a transfer case who had been diagnosed as suffering from 'dementia praecox' had his diagnosis changed to 'mania'.¹²⁹

In 1908 David Thomson, the medical superintendent of Norfolk county asylum read a paper before the M.P.A. in which he recommended that one way to resolve psychiatry's dearth of research initiative and resources would be to establish a postgraduate university diploma to replace the M.P.C., which would be taught through medical departments in the universities. A letter was sent out by Charles Mercier on behalf of the Association in 1910 to all university medical schools; and by the end of the year T.W.McDowall, Colin McDowall's father, who was medical superintendent of Northumberland county asylum, and had lectured on mental diseases at Durham University for many years, had become the first British Professor of Psychological Medicine. From October 1911 not only Durham but Edinburgh, Leeds and Manchester offered courses leading to the D.P.M.. If this diploma lacked state-registration, it had more intellectual and scientific credibility than the M.P.C. because it was taught through university medical schools. A second Chair of Mental Diseases, created at Leeds in 1915, went to J.Shaw Bolton, medical superintendent of the West Riding Asylum, who had been appointed the first senior assistant medical officer at Hellingly when the hospital opened its doors in 1904.¹³⁰

Other debates were also preoccupying the M.P.A. in 1910. As the drive for 'national efficiency' gathered strength,

some members of the Association were keen that psychiatrists' hereditarian understanding of mental disorders should be used to shape a eugenic plan to prevent reproduction amongst those whose future offspring were believed to be most at risk of developing insanity. As might be expected, given his Conservative standpoint and opposition to any further expansion of state intervention, Hayes Newington spoke against any such move. In November 1910, when G.H.Savage read a paper 'On Insanity and Marriage' to a meeting of the M.P.A., Hayes Newington suggested that the laws of evolution were not sufficiently well understood for the state to interfere with confidence, and recommended a social strategy to limit undesirable marriages through the passing of a law which would make it legal for couples who intended to marry to ask whether there was a history of insanity in the family, with any intentional misrepresentation of the facts providing grounds for immediate annulment. Speaking more strongly in November 1911, he:¹³¹

reminded members that from their special point of view they saw so many cases of bad heredity that they were apt to take a gloomy view of the matter ... If Dame Nature had ordained that everybody tainted with insanity would perpetuate the disease, we should have been degenerates thousands of years ago. The world had been going on for many generations, and yet he did not know that we were worse than our predecessors, but probably, in some respects, we were rather better.

Yet if this was almost Spencerian, rather than Morelian in tone, in his work earlier in the year as chairman of

the M.P.A.'s committee on the medical inspection of school children, he had recommended after a visit to Darenth that congenital idiots should be detained for life in industrial colonies where, although they could not be expected to do creative work, they would be able to perform machine-like tasks; and, since there can be little doubt that he would also have favoured strict sexual segregation within these colonies, this would have meant the effective sterilisation of their inmates.¹³²

At the annual meeting of the M.P.A. in 1913 Hayes Newington was presented with a portrait of himself to mark the fortieth anniversary of his membership of the Association, and he spoke at this meeting of retiring. He did not attend the next quarterly meeting, and the death of his cousin Alexander in a car-crash the following January meant that he also sent apologies to the February meeting. In May however he attended the next quarterly meeting, and he went to the annual meeting in July to present his report as treasurer.¹³³ The outbreak of war depleted the Association of younger members, and so Hayes Newington remained in office as treasurer until his death, and regularly attended meetings. In some ways his work on the parliamentary committee in the late-1880s, and the securing of major amendments to the lunacy act of 1890, represented his most forceful achievement; in 1926 the Royal Commission on Lunacy and Mental Disorder questioned the restrictions

on the granting of new licences for private asylums because it had created a virtual monopoly amongst private licensees, leading to poor incentives to maintain standards, or seek new therapeutic initiatives.¹³⁴ Yet if psychiatry in the late-nineteenth and early-twentieth century appeared destitute of therapeutic resources, this was in contrast to the new science of immunology, rather than its own earlier history; and the increasingly over-crowded asylums which had been built in the prosperous mid-Victorian years stood as an embarrassing monument to psychiatry's inability to cure, rather than contain, mental disorders. The emphasis on hospital facilities for curable cases, which Hayes Newington helped to foster, directed resources away from chronic patients towards the minority who were 'curable' in a period when economic decline and the re-structuring of local government would in any case have led to some depletion in levels of care. As Nancy Tomes has argued in the American context the growth of 'scientific medicine' may have meant that chronic patients became increasingly stigmatized by a lack of attention and funds in a way in which they had not been in the mid-nineteenth century.¹³⁵ In the face of their inability to cure patients psychiatrists strove to increase their professional security and prestige, by enhancing their medical respectability, both in the creation of an image of asylums as curative hospitals, and through

establishing a university-taught diploma in psychological medicine, which they hoped would one day to be state-registered like the D.P.H.. Although Hayes Newington was not directly involved in the creation of the D.P.M., he was active in the parallel move to professionalize asylum attendants, and, as someone who was not easily bored by the routine of committee-work, was a patient and skilful negotiator both with the government over proposed legislation on behalf of the M.P.A., and within the Association.

Hayes Newington's Legacy

If his talents as a negotiator helped to secure Ticehurst's future, by the early-1900s Hayes Newington was faced with the difficulty of deciding what should happen to the family business after his death. Neither Alexander, nor Theodore (who lived until 1930), had any children; and Hayes Newington's son was not qualified to succeed his father as medical superintendent. Although Herbert Archer had gone to Cambridge to study medicine in 1895, his own ambition was to be a soldier; and like his uncle Alexander, who had won shooting prizes whilst he was at Cambridge, Herbert Archer became a Captain of the University Rifle Corps, but failed his first M.B..¹³⁶ In choosing Colin McDowall as his successor as medical superintendent, Hayes Newington not only chose a doctor with a scientific approach to psychiatry, but the son of

the first British Professor of Psychological Medicine. Thomas McDowall, who had worked as one of Crichton-Browne's assistant medical officers at Wakefield Asylum in the West Riding of Yorkshire in the mid-1870s, before becoming medical superintendent of Morpeth Asylum in Northumberland, had also been one of the few county asylum superintendents who sat on the M.P.A.'s parliamentary committee during the crucial period of the late-1880s, was a member of the Association's educational committee, and a frequent contributor to the Journal of Mental Science, particularly of reviews of work being done in France; in addition, like Hayes Newington, he was a keen amateur musician and chorister.¹³⁷

Yet if Hayes Newington could feel he was leaving the medical management of the asylum in the hands of the son of someone who shared very similar interests and values to himself, the way in which the financial side of the institution was managed would also affect Ticehurst's future. The trust created by Samuel Newington's will had restricted Hayes Newington's independence in running the asylum. In the utopian asylum of his presidential address, he suggested that:¹³⁸

the Committee of Management should be a small one, and only composed of those who by their aptitude and capacity for continuous work are known to be qualified to help. A large Committee would undoubtedly prejudice, if not stifle, ... a delicate and novel experiment if, as often is the case, the work were done by

the few, while the remainder only interfered on important and critical occasions, just when they would be least qualified to record their votes.

Speaking of the reasons why a new business trust was set up by his grandfather's will, Walter Newington suggested that Hayes Newington had become tired of the trustees 'continually warring, almost, with each other ... jealous of those who did the work and complaining about low dividends'. On the advice of his son Herbert Archer, who had eventually qualified as a solicitor at Cambridge, Hayes Newington established a small business trust to manage the asylum, the proceeds of which were to be divided between four branches of the family - the 'Herberts', the 'Hayes', the 'Samuels' and the 'Alexanders'. As Walter Newington disarmingly admitted, this was a 'racket' in which Herbert Archer and his sister Frances were able to claim double dividends as both 'Herberts' and 'Hayes'.¹³⁹ Amongst those who were appointed business trustees was Samuel Newington's son-in-law, George Montague Tuke, who had been an assistant medical officer at the asylum in the 1870s. Under the management of the trustees however, Ticehurst never regained its lavish style of the 1860s-70s; and to give some measure of the prosperity it had once enjoyed, it is worth noting that when the asylum was sold in the 1960s as a viable business which has so far survived the economic recession of the 1970s and 1980s, Walter Newington suggested they had been able to get a good

price for the institution because its total investments had been worth just over £30,000 - that is, the same as Samuel Newington's annual income in 1869.¹⁴⁰

NOTES: CHAPTER 4

1. Letters of administration to Eleanora Newington re Charles Edmund Hayes Newington M.D., 5 March 1863; probate Samuel Newington, 19 December 1882; probate Alexander Thurlow Newington, 12 July 1898 (Somerset House). Ticehurst Asylum audit, 1875.
2. Alumni Cantab, entries on Alexander Samuel, Campbell and Theodore Newington. Campbell stayed at Caius for only three terms.
3. For Rhys Williams visiting Ticehurst as a consulting physician see for example Case Book 24, p.132. Savage referred 25 patients to Ticehurst between 1 August 1885 and 31 July 1915, or about one in thirteen of all admissions (Register of Admissions, 1881-90; Register of Patients, 1890-1907; and Civil Register, 1907-19).
4. Theodore Newington, 'Feeding by the Nose', Lancet 1 (1879), p.83; Alexander Newington, 'Gunshot Wound of the Brain: Death after Seven Weeks', British Medical Journal 1 (1881), pp.593-4.
5. Ticehurst Asylum audits 1875 & 1881.
6. Although payments from the business were also made to Hayes Newington's brother Reginald Wilmott Hyaes Newington, he did not live at Ticehurst and does not appear to have taken an active part in the running of the institution. Hayes Newington's grandson Walter told me that his great-uncle was an engineer, who helped install electricity in the asylum in the late nineteenth century.
7. Copies of Home Words in East Sussex County Records Office. A.S.L.Newington's obituary was in an uncatalogued collection of papers on the Newington family, also in E.S.C.R.O..
8. A.S.L. & H.F.H.Newington, 'Some Incidents in the History and Practice of Ticehurst Asylum', Journal of Mental Science 47 (1901), pp.62-72.
9. See footnote 7.
10. Visitors' Books, 1869-87, 14 April 1882; 1887-1904, 1 December 1887, 22 May & 29 November 1888, 30 November 1889 and 24 May 1893.
11. A.S.L. & H.F.H.Newington, op.cit., note 8 p.65.
12. Ticehurst Asylum audits, 1880-95; Accounts,

1895-1910, *passim*.

13. Visitors' Books, 1887-1904, 1 December 1887, 24 May, 21 July & 24 November 1893, 16 July 1895, 6 March 1896, 8 February 1897, 1 November 1899, 7 November 1900, 13 November 1901 and 3 February 1904; and 1904-32, 17 July 1909 & 5 July 1912.
14. H.F.H.Newington, 'The Plans of a New Asylum for East Sussex', Journal of Mental Science 46 (1900), p.688. In July 1915 Hayes Newington commented that although Skae's system of classification:
 ...cannot be defended in these more
 scientific days, I feel bound to
 confess that from a broad clinical
 point of view I have found it myself
 to be quite useful.
 (Journal of Mental Science, 61 (1915), pp.495-6).
15. The impact of Morel on British psychiatry is described in W.F.Bynum, 'Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry', in British Journal of Addiction 79 (1984), pp.59-70. Skae's system of classification can be found in Thomas Smith Clouston, Clinical Lectures on Mental Diseases (London: J.& A.Churchill, 1883), p.45. After qualifying MRCS Edin.(1836) Skae was surgeon to the Edinburgh Eye Dispensary and Lock Hospital before being appointed medical superintendent at Morningside in 1846 (Medical Directory). For Skae's interest in syphilis see his obituary in the Lancet, i (1873), p.897.
16. H.F.H.Newington, 'Notes of a Case of Insanity dependent on Syphilis', Journal of Mental Science, 19 (1874), p.558.
17. idem., 'Hemiplegia in relation to Insanity', Edinburgh Medical Journal, 20 (1875), p.23.
18. H.F.H.Newington, 'Some Observations on Different Forms of Stupor, and on its occurrence after Acute Mania in Females', Journal of Mental Science, 20 (1874), p.374; obituary of Thomas Smith Clouston in British Medical Journal, i (1915), p.746.
19. W.F.Bynum, op.cit. note 15, pp.62-3 discusses Clouston's emphasis on the hereditary transmissibility of mental as well as physical characteristics. Margaret Sorbie Thompson, 'The Mad, the Bad and the Sad: Psychiatric Care in the Royal Edinburgh Asylum (Morningside), 1813-94' (Boston University PhD thesis, 1984) more generally discusses Clouston's hereditarian beliefs,

- pp.111-20. The MPA's discussion of Hayes Newington's paper on mania-à-potu can be found in Journal of Mental Science, 20 (1875), pp.656-8.
20. W.F.Bynum, op.cit., note 15, p.63; G.E.Berrios 'Stupor: a conceptual history', Psychological Medicine, 11 (1981), pp.677-88.
 21. A brief glance at the titles of Clouston's publications confirms this trend. Apart from Clinical Lectures on Mental Diseases (London: J.& A.Churchill, 1883) and Unsoundness of Mind (London: Methuen & Co., 1911), Clouston's main publications were: Female Education from a Medical Point of View (1882), The Neuroses of Development (Edinburgh: Oliver & Boyd, 1891), The Hygiene of Mind (London: Methuen & Co., 1906) and Before I Wed (London: Cassell & Co., 1913).
 22. Margaret Sorbie Thompson, op.cit. note 19, pp.121-7.
 23. Although Morningside accommodated some middle and upper class patients in its East House, most inmates at Morningside were working-class. Clouston built an additional house for private patients, Craig House, in 1894, which took upper-class patients, (ibid., pp.86-9 & 95).
 24. H.F.H.Newington, op.cit. note 16, p.557; and op.cit. note 18, pp.385-6.
 25. ibid., loc.cit. and p.384.
 26. H.F.H.Newington, 'Case of an Extraordinary Number of Convulsions occurring in an Epileptic Patient, with Remarks on Nutrient Enemata', Journal of Mental Science 23 (1877), pp.89-91; for an example of notes by Samuel Newington on an epileptic patient, see Case Book 1, p.44.
 27. James McLaren, 'Cases Illustrating the Effect of peripheral Irritations in Epilepsy', Edinburgh Medical Journal, 20 (1874), pp.618-23, especially p.622. 'Miss X.Y.' can be identified as Elizabeth Beeching, (Registry of Admissions, 1845-81, case no.375.
 28. H.F.H.Newington, op.cit., note 26, p.92.
 29. ibid., pp.92-3.
 30. Theodore Newington, 'Feeding by the Nose', Lancet i (1879), p.83.

31. See for example Case Books 29, p.47; 38, pp.143 & 288; F.S. was fed through the nose in ibid., 32, p.86.
32. Anne Digby, Madness, Morality and Medicine. A Study of the York Retreat 1796-1914 (London 1985), p.130. Notes on L.B.T. in Case Book 40, p.162. Francis Wilton, 'A Case of Obstinate Constipation and Inactivity of the Liver', Journal of Mental Science 26 (1880-1), pp.67-9.
33. ibid., p.69.
34. Anne Digby, op.cit. note 32, pp.85-7; for a case of transfer within the asylum, see Case Book 27, p.146; on seclusion and restraint see Medical Visitation Books 1882-4, 1884-6, 1886-9, 1889-94, 1895-8 and 1898-1901, passim; on mustard-packs see A.S.L. & H.F.H.Newington, op.cit. note 8, p.71.
35. Case Books 25, pp.335-64; 26, pp.229-34.
36. Mary Berryman was transferred in December 1885, ibid. 28, pp.233-4; and F.J.S.' relatives were asked to remove her in 1890, ibid., 33, p.15.
37. Journal of Mental Science, 33 (1887-8), pp. 157 & 160.
38. Case Book 27, p.356.
39. cf. W.F.Bynum, op.cit. note 15, p.63.
40. H.F.H.Newington, 'Unverified Prognosis', Journal of Mental Science 32 (1887), pp.225-7.
41. T.S.Clouston, Clinical Lectures (2nd edition, London: Baillière & Co., 1887), pp.317-8; Journal of Mental Science 33 (1887-8), p.163.
42. See G.H.Savage, 'Moral Insanity', Journal of Mental Science 27 (1881), pp.147-55; and J.Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', Journal of Mental Science, 51 (1905), pp.523-7.
43. H.F.H.Newington, 'What are the tests of Fitness for Discharge from Asylums?', Journal of Mental Science, 32 (1887), pp. 497 & 500.
44. G.H.Savage, 'Some Modes of Treatment of Insanity as a Functional Disorder', Guys Hospital Reports 24 (1887), pp.87-8. Michael Clark, 'The Rejection of Psychological Approaches to Mental Disorders in Late

- Nineteenth-Century British Psychiatry' in Andrew Scull (ed), Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era (London: Athlone Press, 1981), pp. 292 & 295.
45. Journal of Mental Science, 26 (1880-1), p.133.
 46. ibid., 32 (1886-7), p.301; H.F.H.Newington, 'Hospital Treatment for Recent and Curable Cases of Insanity', ibid., 35 (1889), p.307.
 47. Case Book 26, pp.247-8.
 48. ibid., p.248.
 49. H.F.H.Newington, op.cit. note 41, p.497.
 50. Case Books 25, pp.215, 240 & 327; 27, p.29; 28, p.216; 30, pp.101 & 161; and 31, p.14.
 51. G.H.Savage, 'Constant Watching of Suicidal Cases', Journal of Mental Science, 30 (1884-5), p.19.
 52. Attendants Book, pp.10, 219 & 257; an attendant was also severely reprimanded for falling asleep whilst on night-watch with a suicidal patient in 1913, p.413. Patients Book, 1846-1904, entry for 12 February 1881.
 53. Handbook for the Instruction of Attendants on the Insane (London: Baillière & Co., 1885), p.57.
 54. Case Book 35, p.270; Alexander Newington, 'Gunshot Wound of the Brain: Death after Seven Weeks', British Medical Journal, 1 (1881), pp.593-4.
 55. Attendants Book, pp.89, 412 & 414.
 56. ibid., pp.30, 226 & 401.
 57. cf. W.F.Bynum, op.cit. note 15; Peter McCandless, 'Curses of Civilisation: Insanity and Drunkenness in Victorian Britain', ibid., p.57; Margaret Sorbie Thompson, op.cit. note 19, pp.186-90.
 58. Attendants Book, pp. 4, 10, 13, 28, 31, 38, 70, 73, 89, 92, 93, 155, 232, 247 & 381; A.S.L. & H.F.H.Newington, op.cit. note 8, pp.68-9.
 59. ibid., p.69; Attendants Book, pp.405 & loose letter.
 60. ibid., pp.83, 380, 410 & 412.
 61. Medical Visitation Books, 1884-6, entry for 25 May

- 1885; 1895-8, entry for 17 January 1898; and 1903-10, entries for 16 April 1906 and 6 July 1908. Visitors' Book, 1887-1904, entry for 22 May 1888.
62. Case Books 28, p.233; 38, pp.203-4; and 40, p.163. Tape of conversation with Walter Newington. Attendants Book, p.374.
 63. ibid., pp.86, 247 & 401; see also F.Wright, 'Given one more chance as he has gone on so well for eight years', p.408. Attendants left to go and work in single care, pp. 4, 75 & 156; and to go and work at Manor House, p.253.
 64. A.S.L. & H.F.H.Newington, op.cit. note 8, p.69.
 65. ibid., p.72; Visitors' Book 1887-1904, entry for 18 November 1891; Case Book 29, p.56.
 66. H.F.H.Newington, 'Some Mental Aspects of Music', Journal of Mental Science 43 (1897), pp.704-21.
 67. Attendants Book, pp.225-6.
 68. Case Book 32, pp.5-6; tape of conversation with Walter Newington.
 69. Case Book 28, pp.200-1.
 70. A.S.L. & H.F.H.Newington, op.cit. note 8, pp.69-70.
 71. Anne Digby, op.cit. note 32, p.129; Medical Visitation Books 1877-82, 1882-4, 1884-6, and 1846-9, passim.
 72. Case Books 27, pp.63-4 and 29, p.343. For examples of sedation with: chloral hydrate, ibid. 28, p.94; 29, p.47; 30, p.158 and 33, p.269; potassium bromide, ibid. 29, p.47; 30, pp.156 & 158; 33, p.269; mustard baths, ibid., 26, pp.129 & 283; chloroform, ibid. 25, p.286; 29, p.343; hyoscyamine, ibid., 26, p.129; 27, p.63; and morphia, ibid., 25, p.335 and 29, p.47.
 73. Hypodermic injections had occasionally been used at Ticehurst since the late 1860s, but were much more frequently used in the late 1880s-90s. For the hypodermic injection of morphia see for example case of C.J., ibid. 36, pp.17-18. Wilfred Robert Kingdon, 'The Diagnosis of Hystero-Epilepsy from Status Epilepticus', Lancet i (1898), p.320.
 74. Quoted in H.F.H.Newington, 'Hospital Treatment for Recent and Curable Cases of Insanity', Journal of

- Mental Science 35 (1889), p.296.
75. G.H.Savage, 'Marked Amelioration in a General Paralytic following a very severe Carbuncle', ibid. 26 (1880-1), p.566.
 76. Case Book 30, p.102.
 77. ibid. 36, p.17. For Edward Spitzka see Bonnie Ellen Blustein, ' "A Hollow Square of Psychological Science": American Neurologists and Psychiatrists in Conflict', in Andrew Scull (ed), op.cit. footnote 44, pp.218-40. Robert Percy Smith, 'Two Cases of Moral Insanity' and 'Cases of Temporary Improvement of Mental Symptoms co-existent with the Development of Local Inflammation with relapse upon the diminution and cure of the latter', Journal of Mental Science, 31 (1885-6), pp.366-70; ibid., 32 (1886-7), pp.298-9.
 78. H.F.H.Newington, loc.cit. note 16; G.H.Savage, 'Presidential Address', ibid., 32 (1886-7), p.319.
 79. J.Pritchard Davies, 'Counter Irritation in General Paralysis', ibid., 31 (1885-6), p.510; 32 (1886-7), pp.304-5; and 33 (1887-8), p.161.
 80. Case Book 36, p.258.
 81. A.S.L. & H.F.H.Newington, op.cit., note 8, p.70.
 82. Journal of Mental Science, 41 (1895), p.636; Clouston quoted in Richard Eager, 'An Investigation as to the Therapeutic value of Thyroid Feeding in Mental Diseases', ibid. 58 (1912), p.427.
 83. Cases of W.A.E. and C.M. in Case Books 36, pp.226-32 and 37, p.284; and A.S.L. & H.F.H. Newington, op.cit. note 8, p.69.
 84. ibid., pp.71-2; Case Books 28, pp.13 & 199 and 38, p.135; and W.R.Kingdom, op.cit., note 73.
 85. Medical Journals 1898-1901, 1901-3, 1903-10 and 1910-15, passim.
 86. Reports on veronal were published in the British Medical Journal's epitome on therapeutics, 1903-4; Case Books 36, p.286; 38, pp.331-2 and 40, pp.64-5.
 87. Obituary of H.F.H.Newington in British Medical Journal, 11 (1917), p.201.
 88. Medical Directory (1890) & (1915); for Hellingly see

- H.F.H. Newington, 'The Plans of a New Asylum for East Sussex', Journal of Mental Science (1900) 46, p.677; between 1890 and 1910 the number of cases in single care rose from 446 to 593. Growth was most rapid in private beds in county asylums which increased three-fold in the same time period, from 1,027 to 3,366 (Forty-Fourth Lunacy Commissioners' Report (PP1890.XXXV.1-), p.135; Sixty-Fourth Lunacy Commissioners' Report (PP1910(204.)XLI.1-), p.247).
89. Register of Admissions, 1881-90; Register of Patients, 1890-1907; Civil Register, 1907-19.
 90. Obituary of Hayes Newington in the British Medical Journal ii (1917), pp.200-1.
 91. G.H.Savage, 'The Pathology of Insanity', British Medical Journal ii (1884), p.239; T.S.Clouston, British Medical Journal, ii (1886), pp.581-3.
 92. Journal of Mental Science 34 (1888-9), p.149.
 93. ibid., p.454.
 94. Medical Directory (1888).
 95. Journal of Mental Science, 33 (1887-8), pp. i, 324-5, appended 'Observations and Suggestions on the Lunacy Acts Amendment Bill by the Parliamentary Committee of the Medico-Psychological Association', pp.5-7.
 96. ibid., p.450.
 97. ibid., loc.cit., and p.452.
 98. ibid. (1889-90) 35, pp. i & 441.
 99. ibid. (1888-9) 34, pp.471 & 497.
 100. ibid., p.397.
 101. ibid., 33 (1887-8), appended 'Observations and Suggestions....', p.5.
 102. See discussion in ibid., p.326; and ibid., 33 (1889-90), pp.510-1.
 103. ibid., pp.400 & 496.
 104. ibid., p.499.
 105. For a discussion of the controversy which led to Savage's resignation see Stephen Trombley 'All That

Summer She Was Mad'. Virginia Woolf and Her Doctors (London: Junction Books, 1981) pp.146-9; see also British Medical Journal ii (1888), p.1059.

106. Journal of Mental Science, 34 (1888-9), p.624, 625-6 and 628-9.
107. ibid. 35 (1889-90), pp.220 & 399.
108. ibid., pp.142 & 220.
109. ibid., pp.133-4.
110. ibid., pp.282-3; 439-41, 444-5 & 451-3.
111. ibid., pp.295 & 300.
112. ibid., pp.293, 300 & 312.
113. ibid., pp.303 & 309.
114. ibid., pp.300 & 302.
115. ibid., p.313.
116. ibid., pp.446-51.
117. ibid. 36 (1890), pp.586-7.
118. ibid., pp.586-7.
119. H.F.H.Newington, op.cit. note 88, pp.673-86, especially p.678.
120. ibid., p.684; and 35 (1889-90), pp.314-5.
121. ibid., p.459.
122. ibid., 37 (1891), p.535.
123. ibid. 34 (1888-9), p.454; 36 (1890), pp.152-3; 47 (1901), p.841.
124. ibid., 51 (1905), pp.750 & 839.
125. G.H.Savage, loc.cit. note 91; Journal of Mental Science 52 (1906), pp.821-2, 824 & 827.
126. ibid., pp.825-6; see also ibid. (1905) 51, p.203.
127. Medical Register, 1907-19.
128. Journal of Mental Science 58 (1912), pp.306 & 308-9.

129. Medical Register, 1907-30, case numbers 816, 857 & 897.
130. Journal of Mental Science, 56 (1910), pp.373-5; Medical Directory (1910) & (1915).
131. Journal of Mental Science, 57 (1911), p.1067; ibid. 58 (1912), pp.60-1.
132. ibid. 57 (1911), p.735.
133. ibid. 59 (1913), pp.694-5; ibid., 60 (1914), pp.157, 336, 532 & 644.
134. See William Ll. Parry-Jones, The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries, (London: Routledge & Kegan Paul, 1972), p.27.
135. Nancy Tomes, A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-83, (Cambridge and New York: Cambridge University Press, 1985), pp.309 & 321.
136. Tape of conversation with Walter Newington.
137. Obituary of T.W.McDowall in British Medical Journal, ii (1936), p.569.
138. H.F.H.Newington, op.cit. note 46, p.312.
139. Tape of conversation with Walter Newington.
140. ibid..

CONCLUSION

The long period of time covered by this thesis makes it difficult to sum up with uniform conclusions. Although there were strong continuities throughout Ticehurst's history, each generation of the Newington family moulded the asylum in distinctive ways. The first chapter emphasised that, although the private madhouse opened by Samuel Newington took some middle-class patients, it was a far more modest establishment than the mid-Victorian image which has on the whole prevailed in previous historical accounts.¹ In addition, the fragmented evidence which has survived from this period suggests that Roy Porter is right to argue that there was not a dramatic change in therapeutic practices between the late-eighteenth and early-nineteenth centuries;² and also that the dichotomy between 'moral' and 'medical' treatment should not be exaggerated - elements of both appear to have been applied at Ticehurst.

For the early period it was not possible to say very much about the attitude of the Newingtons to their work except that Samuel Newington had no non-conformist religious affiliations as many private asylum-keepers did.

However, Thomas Mayo's writings make it clear that Ticehurst was strongly influenced in the 1820s-30s by the Evangelicals' cry for urgent moral reform, and this was

of crucial significance to the transformation of Ticehurst into a more exclusive and upper-class institution under Charles Newington. Foucault's insight that the organisation of early-nineteenth century asylums was closely connected with real historical changes in the bourgeois family was illuminating in understanding this transition, although Mayo was more at ease with the authoritarian aspects of his paternalist role than Pinel or Samuel Tuke, and the 'prestige of patriarchy', or the use of images of benevolent paternalism to defend particular strategies at every social level from the family, to the asylum, to local and national government, was a less unidirectional transition than Foucault's analysis suggests.³ Mayo's emphasis on a contract of cure between patient and physician has echoes in a more liberal reading of psychoanalysis than Foucault's argument against its latent authoritarianism permits; and indeed in the only grounds for treatment which the anti-psychiatrist Thomas Szasz is prepared to recognize as legitimate. Like Szasz, Mayo emphasised the moral responsibility of the insane subject, but unlike him he used this line of reasoning to defend an active and interventionist psychiatric medicine.⁴ In Doerner's sense Mayo's 'psychiatry' was evidently aimed at 'the disciplining of bourgeois society'; but like Doerner, I believe that psychiatry also has an emancipatory potential which Foucault's over-simplified analysis does

not leave room for.⁵

The mid-Victorian years at Ticehurst had already to some extent been documented by Parry-Jones and Scull. Chapter 3 argued that in two important ways Scull's description misrepresented Ticehurst. Firstly, whilst moral therapy was clearly central to treatment at Ticehurst it was practised alongside medical therapeutics which were regarded as of at least equal importance by Charles Hayes and Samuel Newington. The emphasis on the growth and importance of moral therapy has obscured the stress in Victorian medico-psychological practice on the interaction and mutual influence of the body and the mind - that is, on psychophysiology. Scull's mocking dismissal of treatment in institutions like Ticehurst as 'moral therapy ... with a vengeance' underestimates the seriousness of the historical actors' genuine therapeutic aspirations. Scull also underestimates Ticehurst's turnover of patients, but more importantly his emphasis on 'cure' rather than 'care' is historically misleading: the Newingtons were able to satisfy the perceived needs of their clientele, who may have hoped for a cure or recovery, but knew that in many cases the most they could reasonably expect was respectful and considerate nursing. Whilst Scull is generally critical of the medical model of insanity he shares its prejudice in favour of therapeutic results rather than quality of care.⁶ As

Nancy Tomes has argued in the American context, the mid-nineteenth century may have represented a high-point in the care of the chronic insane, and even by Victorian standards, Ticehurst was exceptionally well-provided in terms of staff and entertainments.⁷

Current debates surrounding the closure of mental hospitals tend to stereotype everything that is undesirable with the epithet 'Victorian'.⁸ Whilst large, remote buildings are a legacy of the mid-nineteenth century, the image of stark and environmentally-impoverished asylum wards may more accurately be one which belongs to the late-nineteenth and twentieth-century, after the development of the biomedical model, and separation of 'curable' and 'incurable' patients. As the last chapter emphasised, the late-Victorian - Edwardian period saw some falling away from high standards of care for the chronic insane at Ticehurst, linked to the growth of a therapeutically pessimistic model of insanity as hereditary degeneration, as well as the development of the biomedical model which favoured dramatic results. Michael Clark has also stressed the growth of a determination within psychiatry in the later-nineteenth century to shed responsibility for chronic patients. Hayes Newington's espousal of the 'hospital' treatment for acute cases of insanity was typical of his profession in this respect. In addition,

Clark has seen this drive as a response to psychiatry's low status within the medical profession, and an attempt to map out a province in preventive and curative medicine rather than custodial care.⁹ Whilst this would seem to be an accurate assessment, both Clark and Scull have perhaps exaggerated psychiatry's political ineffectiveness in the later-nineteenth century.¹⁰ Certainly the Medico-Psychological Association's parliamentary committee had considerable impact on the 1890 Lunacy Act, particularly in its treatment of the private sector.

A continuous theme throughout this thesis has been psychiatry's links with the defence of prevailing moral standards and norms. Chapter 2 stressed that Mayo saw a naturalistic understanding of mental disorders as compatible with Christian ethics, and therefore would have seen the advocacy of Evangelical standards of behaviour as one of the duties, rather than a travesty, of a medical professional role. By the mid-Victorian period moral precepts were closely integrated into medical psychology, so that although there was a decline in the number of people certified as 'morally insane' at both Ticehurst and the Retreat, this did not reflect an absence of concern with moral issues. Only with the more substantial challenge to conventional morality in the late-Victorian - Edwardian era did psychiatry overtly

re-assert its fundamental incorporation of ethical standards. Michael Clark has argued that increasing secularization meant that psychiatry was exceptionally well-placed to articulate a conservative morality, and be heard with the new respect accorded to science rather than the diminishing respect accorded to the received authority of the Church.¹¹ But in many respects this later re-assertion was far less successful than the early nineteenth-century appeal for moral reform. In the twentieth century the development of a view of scientific truth as value-neutral has led to strong criticism of psychiatry's latent moralism, and the belief that psychiatry will achieve scientific credibility only when it has shed its culturally-determined load of moral values. As Michael Shepherd has expressed it: 'What is needed ... is to divest the concept of mental health of ethical and political content'.¹² Like Aubrey Lewis, Shepherd argues that health should be defined as an adequate performance of physiological and psychological functions, rather than in terms of social deviance.¹³ A full exploration of this issue was beyond the scope of this thesis, but like Andrew Scull I believe the history of psychiatry suggests it is a fundamentally moral enterprise, and I find it difficult to conceive of a standard for 'psychological functions' which would not incorporate some moral values.

A second theme has been the way in which medical theory links to medical practice, and how national trends affected an institution with strong local and familial traditions. Perhaps surprisingly, the main shifts in treatment at Ticehurst did mirror national developments, not only in those like the reduction of mechanical restraint which were monitored by the commissioners, but despite its lavish resources in a deterioration in treatment in the last decades of the nineteenth century, associated with the decline in therapeutic optimism. Changes in medical practice did not result from developments in medical theory, although traditional practices were given new rationales as theoretical conceptions changed, for example in the application of reflex physiology to the use of mechanical restraint, and of bacteriology to the development of a toxaemic rather than a hyperaemic hypothesis to explain the alleged benefits of blood-letting and purgation. Rather, as John Harley Warner has argued of physical medicine in the first half of the nineteenth century, the aggressiveness of medical intervention is a sensitive barometer of professional security.¹⁴ As a 1986 report on the education of psychiatrists suggests, one desirable characteristic in psychiatrists may be the capacity to tolerate the poor quality of psychiatric knowledge without 'clinical non-commitment, denial or disdain for psychiatry, or by contrast a contempt for the relevance

of knowledge or a shallow pretence to it'. The evidence from Ticehurst indicates that the last of these possible reactions to stress may be the most important.

Strikingly, this report also emphasises that 'therapeutic optimism' is a valuable quality to look for in candidates who apply for training.¹⁵

One of the main arguments of this thesis has been that, if Ticehurst was influenced by national trends, it was also to some extent exceptional; and of course the standards of care Ticehurst's clientele were able to pay for cannot be taken as 'typical of Victorian England. If Charles Hayes and Samuel Newingtons' underlying preconceptions - their belief in the healing powers of nature, shunning of heroic medication, and faith in a supportive regimen and mental diversions - were shared by some of their colleagues, Ticehurst's financial resources meant that it was nevertheless unusual in its ability to carry these objectives into effect. Unusual, but not unique: Anne Digby's work on the Retreat suggests that even in a larger registered hospital the early-mid nineteenth century was a period of relatively individualized, medically-benign treatment. Both Ticehurst and the Retreat clearly incorporated strong ethical beliefs into their therapeutic objectives which reflected social preoccupations; but nevertheless, as Nancy Tomes has argued of the Pennsylvania Hospital, from

a humanitarian standpoint the level of care achieved, particularly of chronic patients, is deserving of respect.¹⁶ In an article in the Lancet in 1985 Trevor Turner suggested that the range of provisions available to Ticehurst's clientele in the mid-nineteenth century might provide one possible model for a present-day balance between community and small-scale institutional care.¹⁷ There is not room here to enter into the debate surrounding the present shift towards 'community care'. This thesis has been as strongly critical of Foucault and Scull's pessimistic analyses of the growth of a repressive psychiatric 'discourse' and a 'therapeutic state' as it has of the eupeptic vision of earlier whig historiography: both are too unidirectional, and fudge the historical complexities. But if any implications for the present are to be drawn from this thesis, I would like it to contribute to a greater self-questioning within psychiatry of some of the possible human costs (as well as benefits) of a strong commitment to the biomedical model.

CONCLUSION: NOTES

1. William L1. Parry-Jones emphasise that Ticehurst took less than twenty patients when it first opened, but also suggests that 'Parish patients were not received' (The Trade in Lunacy. A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries, (London: Routledge & Kegan paul, 1972), p.119).
2. Roy Porter, 'Was there a Moral Therapy in Eighteenth-Century Psychiatry?', Lychnos (1981-2), pp.12-26; this argument is extended in his forthcoming book, Mind-Forg'd Manacles: Madness in England, c.1650-c.1815, (London: Athlone Press, forthcoming 1987).
3. Michel Foucault, Madness and Civilisation: A History of Insanity in the Age of Reason, (London: Tavistock Publications, 1967), quote taken from p,253.
4. The most frequently referred to exposition of Szasz's ideas is probably The Manufacture of Madness, (London: Paladin, 1973); but for his arguments concerning the moral responsibility of the insane and its implications for psychiatry see especially Law, Liberty and Psychiatry, (London: Routledge & Kegan Paul, 1974).
5. Klaus Doerner, Madmen and the Bourgeoisie: A Social History of Psychiatry and Insanity. (Oxford: Blackwell, 1981), p.291
6. Andrew Scull, Museums of Madness. The Social Organization of Insanity in Nineteenth-Century England, (London: Allen Lane, 1979), pp.207-8.
7. Nancy Tomes, A Generous Confidence. Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-83. (Cambridge and New York: Cambridge University Press, 1985), pp.319-21.
8. See for example Harry Reid and Alban Wiseman, When the Talking Has to Stop. Community Care in Crisis; the Case of Banstead Hospital, (London: MIND, 1986), Introduction:
 Victorian values should have no place
 at a time when we are supposedly
 moving away from the Victorian legacy
 of larger remote and inappropriate
 mental hospitals.
9. Michael Clark, ' 'The Data of Alienism':
 Evolutionary Neurology, Physiological Psychology,

and the Reconstruction of British Psychiatric Theory, c.1850-c.1900', (Oxford University D.Phil. thesis, 1982), p.304.

10. ibid., p.306; and Andrew Scull, op.cit. note 6, p.258.
11. Michael Clark, op.cit. note 9, p.30.
12. Michael Shepherd, The Psychosocial Matrix of Psychiatry. Collected Papers. (London: Tavistock Publications, 1983), p.18.
13. ibid., pp.18-19.
14. John Harley Warner, 'Therapeutic Explanation and the Edinburgh Blood-Letting Controversy: Two Perspectives on the Medical meaning of Science in the Mid-Nineteenth Century', Medical History, 24 (1980), pp.241-58.
15. Henry Walton (ed), Education and Training in Psychiatry. A Case Study in the Continuity of medical Education, (London: King's Fund, 1986), p.43.
16. Nancy Tomes, op.cit., p.321.
17. T.H.Turner, 'The Past of Psychiatry: Why Build Asylums?', Lancet, ii (1985), pp.709-11.

TABLE 1Admissions: The First Five Years

Numbers in brackets represent known re-admissions.
Years run 1 August - 31 July.

	Men	Women	Sex Unknown	All
1792-3	9	10		19
1793-4	7(3)	16(2)		23(5)
1794-5	13	12(1)		25(1)
1795-6	10(3)	4(2)	1	15(5)
1796-7	12(5)	6(1)	1	19(6)
SUB-TOTAL	51(11)	48(6)	2	101(17)
TOTAL	62	54	2	118

Source: Bill Book, 1792-1802.

TABLE 2Number of Patients Resident in Asylum, 1793-7

Figures are for 31 January and 31 July of each year.

	Men	Women	Sex Unknown	All
1793	5	1		6
	4	4		8
1794	6	4		10
	5	2		7
1795	7	2		9
	8	8		16
1796	9	4	1	14
	9	4		13
1797	8	4		12
	8	7	1	16

Source: See Table 1

TABLE 3Admissions: The First Twenty-Five Years

Numbers in brackets represent known re-admissions.
Years run from August - 31 July.

	Men	Women	Sex Unknown	All
1792-7	51(11)	48(6)	2	101(17)
1797-1802	50(9)	33(8)		83(17)
1802-7	54(5)	47(5)	3	104(10)
1807-12	66(4)	52(12)	2	120(16)
1812-17	62(11)	67(22)	1	130(33)
SUB-TOTAL	283(40)	247(53)	8	538(93)
TOTAL	323	300	8	631

Sources: Bill Books 1792-1802, 1802-11, 1811-19.

TABLE 3.1Pauper Admissions: 1792 - 1817

Numbers in brackets represent known re-admissions.
Years run 1 August - 31 July.

	Men	Women	Sex Unknown	All
1792-7	0	0	0	0
1797-1802	3	2	0	5
1802-7	5	5	1	11
1807-12	*9(1)	*4	1	14(1)
1812-17	7(3)	11(4)	1	19(7)
SUB-TOTAL	24(4)	22(4)	3	49(8)
TOTAL	28	26	3	57

*Including one patient who only had part of their bill paid by the over-seers.

Sources: See Table 3.

TABLE 4Number of Patients Resident, 1795 - 1815

Figures are for 31 July of each year.

	Men	Women	Sex Unknown	Total
1795	8	8		16
1800	8	3		11
1805	16	7		23
1810	17	13		30
1815	18	14	1	33

Sources: See Table 3.

TABLE 5Fees Charged to Patients Resident, 1795 - 1815

Figures are for 31 July of each year. Fees are rounded to the nearest half-guinea. The median charge for each year is marked with an asterisk.

Per week	1795	1800	1805	1810	1815
1/2 g.				1	1
1 g.	10*	5	11	6	5
1 1/2 g.	4	3*	5*	7	8
2 g.	1	2	4	11*	10*
2 1/2 g.			1	1	2
3 g.	1	1	1	1	3
3 1/2 g.				2	2
4 g.					
4 1/2 g.				1	1
5g.or more			1		1

Sources: See Table 3.

TABLE 6

Number of Admissions to Ticehurst in Relation to the
Size of the Originating Town or Parish, 1792-1817

SUSSEX

In Order of Population Size	In Order of Number of Admissions	Admissions per five years
Brighton (12,012)	Hastings (17)	Brighton (1:240)
Lewes (6,221)	Frant (12)	Lewes (1:113)
Hastings (3,848)	Lewes (11)	Rye (1: 54)
Rye (2,681)	Brighton (10)	Mayfield (1: 46)
Mayfield (2,079)	Rye (10)	Hastings (1: 45)
Burwash (1,603)	Mayfield (9)	Burwash (1: 36)
Frant (1,439)	Burwash (9)	Northiam (1: 25)
Northiam (1,114)	Northiam (9)	Frant (1: 24)

KENT

In Order of Population Size	In Order of Number of Admissions	Admissions per five years
Tonbridge (5,932)	Tonbridge (12)	Tonbridge (1:99)
Cranbrook (2,994)	Tenterden (12)	Cranbrook (1:54)
Tenterden (2,786)	Cranbrook (11)	Tenterden (1:46)
Tun. Wells(<2,500)*	Yalding (11)	Yalding (1:37)
Yalding (2,059)	Tun. Wells(9)	Tun. Wells n/a

*The population of Tunbridge Wells was divided between the three parishes of Frant, Speldhurst (1,901) and Tonbridge, and no separate figures are given for its population in the 1811 census. In 1826 its population was estimated to be about 2,500.

Sources: Abstracts of Population Returns for 1811 (PP1812(316.)(317.)XI; Bill Books 1792-1802, 1802-11, 1812-19. Pigot and Co.'s London and Provincial New Commercial Directory, (London: J.Pigot and Co., 1826-7).

TABLE 7

Person or Persons by Whose Direction Patients Were
Admitted to Ticehurst, 1792 - 1817

	Men	Women
Man, or Men, of the Same Surname	10	29
Woman of the Same Surname	16**	1
Person, or Persons, of the Same Surname (Sex Unknown)	12	8
Father	4*	1*
Husband		2
Mother	3**	
Wife	3	
Man of Same Surname and Man of Different Surname	1	
Man, or Men, of Different Surnames	4	2
Brother-in-Law	1*	
Woman, or Women, of Different Surnames	1	1
Aunt		1*
Person of Different Surname (Sex Unknown)	1	4

Notes:

* including one person from the 1828 admissions book

** including two people from the 1828 admissions book

Sources: Country Register; Account of Patients Admitted,
1828.

TABLE 8

Length of Stay of Patients Resident, 1795 - 1815
 Figures are for 31 July of each year. The median
 length of stay for each year is marked with an asterisk

	1795	1800	1805	1810	1815
Up to 4 weeks	1				
4+ - 13 weeks	3		1	2	1
13+ - 26 weeks	1		1	2	6
26 weeks+ - 1 year	2		2	2	2
1+ - 2 years	3*	2	2	1	1
2+ - 5 years	2	1	4	5	4
5+ - 10 years	1	3*	4*	4*	4*
10+ - 20 years	0	1	4	6	6
20+ years	3	4	5	8	9
TOTAL	16	11	23	30	33

Sources: Bill Books 1792-1802, 1802-11, 1812-19,
1819-26, 1826-32, 1832-9 and 1840-6; Register
of Discharges and Deaths 1845-90.

TABLE 8.1

Length of Stay of Patients Resident, 1795 - 1815,
Distinguished by Sex

Figures are for 31 July of each year.
 The median length of stay for each column is marked
 with an asterisk.

	1795		1800		1805		1810		1815		
	M	F	M	F	M	F	M	F	M	F	?
Up to 4 weeks		1									
4+ - 13 weeks		3*			1		1	1			1
13+ - 26 weeks		1			1		1	1	2	4	
26 weeks+ - 1 year	2				1	1	1	1		2	
1+ - 2 years	2	1	1	1	1	1*	1		1		
2+ - 5 years	*	2		1*	4		1	4*	2	2*	
5+ - 10 years	1		3		4*		4*		4		
10+ - 20 years			*	1	2	2	2	4	3*	3	
20+ - 35 years	2		2		2		4		3		
35+ - 55 years			1		1		1	1	2	2	
55+ years	1		1		1	1	1	1	1	1	
TOTAL	8	8	8	3	16	7	17	13	18	14	1

Sources: see Table 8.

TABLE 9

Length of Stay of First Admissions, 1792 - 1817, Distinguished by Sex

Years run 1 August - 31 July for each year. The median length of stay for men & women is marked with an asterisk.

	1792-7			1797-1802			1802-7			1807-12			1812-17			TOTAL		
	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?	M	F	?
Up to 7 days		4		2	1		1	1		1	1					4	7	
7+ days - 4 weeks	9	8		10	5		9	6		5	2	1	3	2		36	23	1
4+ -13 weeks	12	19*		25*	14*		13	22*	2	27	20		20	21	1	97	96*	3
13+ -26 weeks	13*	11	1	7	6		12*	12		16*	14*	1	17*	21*		79*	64	2
26+ weeks - 1 year	7	1	1	3	1		8	4		12	5		8	15		38	26	1
1+ - 2 years	3	1		1	1		3	1		1	1		6	3		14	7	
2+ - 5 years		3			2		3	1			6		5	3		8	15	
5+ - 10 years	1			2			1			4						8		
10+ - 20 years					2		2				2		1	1		3	5	
20+ - 35 years	2						2									4		
35+ - 55 years	1										1		2	1		3	2	
55+ years	1				1											1	1	
Unknown	2	1							1							2	1	1
TOTAL	51	48	2	50	33		54	47	3	66	52	2	62	67	1	283	247	8

Sources: see Table 8.

TABLE 10Condition at Discharge of All Admissions, 1792 - 1817

Years run 1 August - 31 July. Numbers in brackets represent known re-admissions.

	In Unknown Condition			Well		Transferred		
	Men	Women	?	Men	Women	Men	Women	?
1792 - 7	36(10)	36(6)	2		1	4(1)		
1797-1802	39(6)	23(8)			1	(1)		
1802 - 7	29(1)	30(1)	1	7	4	2(1)	(1)	1
1807 -12	29(2)	31(9)	2	18(1)	9(2)			
1812 -17	28(7)	41(17)	1	19(1)	14(1)		2(1)	
SUB- TOTAL	161(26)	161(41)	6	44(2)	29(3)	6(3)	2(2)	1
TOTAL	187	202	6	46	32	9	4	1

Sources: see Table 8.

TABLE 11Outcome of Stay for Patients Resident, 1795 - 1815

Figures are for 31 July of each year.

	Died			Discharged			Unknown Outcome			
	Men	Women	Both	Men	Women	Both	Men	Women	?	All
1795	3	1	4	4	5	9	1	2		3
1800	6	1	7	1	2	3	1			1
1805	7	5	12	5	1	6	5			5
1810	10	7	17	5	6	11	2			2
1815	8	6	14	7	8	15	3		1	4

Sources: see Table 8.

TABLE 12Admissions to the Asylum, 1817-42

Numbers in brackets represent known re-admissions.
Years run from 1 August - 31 July.

	Men	Women	Sex Unknown	All
1817-22	59(4)	57(7)	1	117(11)
1822-7	40(4)	46(7)	1(1)	87(12)
1827-32	34(3)	38(3)		72(6)
1832-7	28(6)	21(2)		49(8)
1837-42	24(1)	10(1)		34(2)
SUB-TOTAL	185(18)	172(20)	2(1)	359(39)
TOTAL	203	192	3	398

Sources: Bill Books 1811-19, 1819-26, 1826-32, 1832-9,
1840-6.

TABLE 12.1Pauper Admissions to the Asylum, 1817-42

Numbers in brackets represent known re-admissions.
Years run 1 August - 31 July.

	Men	Women	Both
1817-22	1	3(1)	4(1)
1822-7		3*	3
1827-32			
1832-7			
1837-42			
SUB-TOTAL	1	6(1)	7(1)
TOTAL	1	7	8

* Including one patient who only had part of her bill paid by the parish.

Sources: See Table 12.

TABLE 13Number of Patients Resident in Asylum, 1820-40

Figures are for 31 July of each year.

	Men	Women	Both
1820	27	23	50
1825	29	18	47
1830	30	18	48
1835	30	25	55
1840	34	27	61

Sources: See Table 12.TABLE 14Fees Charged to First Admissions to the Asylum, 1817-42

Years run 1 August - 31 July. Fees are rounded to the nearest half-guinea. The median charge for each five-year period is marked with an asterisk.

Per Week	1817-22	1822-7	1827-32	1832-7	1837-42
1/2g.			1		
1g.	67*	46*	21	4	2
1 1/2g.	15	11	14*	7	3
2g.	14	11	12	8	2
2 1/2g.	3	1	3	2	3
3g.	5	9	5	6*	9*
3 1/2g.	4	3		3	1
4g.	4		10	9	3
4 1/2g.	1	2	1	2	
5g.	1	3	1	1	
5 1/2g.	2			2	
6g.	1			1	2
6 1/2g.			2		
7g. or more			2	1	2
Unknown		1		3	7
TOTAL	117	87	72	49	34

Sources: See Table 12.

TABLE 15Fees Charged to Patients Resident in Asylum, 1820-40

Figures are for 31 July of each year. Fees are rounded to the nearest half-guinea. The median charge for each year is marked with an asterisk.

Per Week	1820	1825	1830	1835	1840
1/2g.	1				
1g.	18	12	3	4	4
1 1/2g.	8*	7	8	12	11
2g.	10	14*	11	8	13
2 1/2g.	1	2	6*	3	7*
3g.	3	4	4	4*	7
3 1/2g.	4	2	1	5	4
4g.	2	3	10	9	6
4 1/2g.	2	2	1	1	1
5g.			2	1	1
5 1/2g.		1	1	3	1
6g.	1				1
6 1/2g.				1	
7g. or more			1	4	5
TOTAL	50	47	48	55	61

Sources: See Table 12.

TABLE 16

Former Occupations of First Admissions to Asylum,
1 August 1817 - 31 July 1845

	Men	Women	Both
<u>INDEPENDENT:</u>	18*	17	35
No occupation/none	1	4	5
Gentleman	1		1
<u>CHURCH:</u>			
Clergyman	13		13
<u>ARMY:</u>			
General	1		1
Officer	1		1
Colonel	1		1
Captain	6		6
Cornet	1		1
<u>MEDICINE:</u>			
Physician	1		1
Surgeon	3		3
<u>LAW:</u>			
Solicitor	2		2
Law Student	1		1
<u>AGRICULTURE:</u>			
Yeoman	1		1
Farmer	5		5
<u>COMMERCE/TRADE:</u>			
Merchant	3		3
Silk Manufacturer	1		1
Auctioneer	1		1
Miller	2		2
Grocer's son	1		1
<u>CLERKS:</u>			
General	1		1
Bank of England	1		1
India House	1		1
Assistant Teacher		1	1
Painter	1		1
Sailor	1		1
<u>DOMESTIC SERVICE:</u>			
Butler	1		1
Servant		1	1
Wife		8	8
Spinster		3	3
Widow		1	1
Unknown	125	148	273
TOTAL	195	183	378

* including two baronets.

Sources: see Table 12; also Account of Patients
Admitted, 1828 and Admission of Patients,
1843-5.

TABLE 16.1

<u>Former Occupations of First Admissions to the Asylum,</u> <u>1 August 1827 - 31 July 1832.</u>			
	Men	Women	Both
<u>INDEPENDENT:</u>	3	3	6
No occupation/none		4	4
<u>CHURCH:</u> Clergyman	1		1
<u>ARMY:</u> Officer	1		1
Captain	2		2
Cornet	1		1
<u>MEDICINE:</u> Surgeon	1		1
<u>LAW:</u> Solicitor	1		1
<u>AGRICULTURE:</u> Farmer	5		5
<u>COMMERCE/TRADE:</u>			
Merchant	2		2
Auctioneer	1		1
Miller	2		2
Grocer's Son	1		1
<u>CLERK:</u> Bank of England	1		1
Assistant Teacher		1	1
Painter	1		1
<u>DOMESTIC SERVICE:</u> Butler	1		1
Servant		1	1
Wife		8	8
Spinster		2	2
Widow		1	1
Unknown	6	18	24
TOTAL	30	38	68

Sources: See Table 16.

TABLE 16.2

<u>Former Occupations of First Admissions to the Asylum,</u> <u>1 August 1832 - 31 July 1845</u>			
	Men	Women	Both
<u>INDEPENDENT:</u>	11*	13	24
No occupation	1		1
<u>CHURCH:</u> Clergyman	9		9
<u>ARMY:</u> Colonel	1		1
Captain	3		3
<u>MEDICINE:</u> Surgeon	1		1
<u>LAW:</u> Law Student	1		1
<u>COMMERCE/TRADE:</u>			
Silk Manufacturer	1		1
Sailor	1		1
Unknown	32	30	62
TOTAL	61	43	104

* including two baronets.

Sources: See Table 16.

TABLE 17

Length of Stay of First Admissions to Asylum, 1817-42

Years run from 1 August to 31 July for each year. The median length of stay for each five-year period is marked with an asterisk.

	1817-22	1822-7	1827-32	1832-7	1837-42
Up to 7 days	1				
1+ - 4 weeks	7	2	5		1
4+ - 13 weeks	35	20	19	2	3
13+ - 26 weeks	34*	27*	17*	10	6
26+weeks-1 year	14	14	12	10	6
1+ - 2 years	7	4	2	8*	4*
2+ - 5 years	6	11	4	7	4
5+ - 10 years	3	5	2	3	1
10+ - 20 years	3	1	5	3	3
20+ - 35 years	2	2	4	5	5
35+ - 55 years	5	1	1	1	
55+ years			1		
Unknown					1
TOTAL	117	87	72	49	34

Sources: see Table 12; also Register of Discharges and Deaths 1845-90.

TABLE 18

Length of Stay of Patients Resident in Asylum, 1820-40

Figures are for 31 July for each year. The median length of stay for each year is marked with an asterisk.

	1820	1825	1830	1835	1840
4+ - 13 weeks	2	2			
13+ - 26 weeks	5	3	1	2	
26+weeks-1 year	6	1	1	1	1
1+ - 2 years	4	1	1	4	2
2+ - 5 years	7	5	6	3	4
5+ - 10 years	4*	6	8	4	3
10+ - 20 years	7	7*	6	12	12
20+ - 35 years	4	8	10*	13*	21*
35+ - 55 years	9	11	12	12	13
55+ years	2	3	3	4	5
TOTAL	50	47	48	55	61

Sources: see Table 17.

TABLE 19**Home Countries and Counties of First Admissions to the Asylum, 1817-42**

	1817-22	1822-7	1827-32	1832-7	1837-42
ENGLAND:					
Sussex	47	28	22	9	14
Kent	40	30	35	13	2
London	12	9	6	2	3
Middlesex	2	3	2	3	
Surrey	3	1	3		1
Essex	1	1			
Oxfordshire		2	1		
Hertfordshire		1			
Hampshire			1	1	
Staffordshire			1		
Buckinghamshire				1	
Yorkshire				1	
Devonshire					1
IRELAND	1				
WALES				1	
FRANCE				1	
UNKNOWN	11	12	1	17	13
TOTAL	117	87	72	49	34

Sources: see Table 16.

TABLE 20

Number of Admissions to Ticehurst Asylum in Relation to
the Size of the Originating Town or Parish, 1817-42

SUSSEX

In Order of Population Size	In Order of Number of Admissions	Admissions per Five Years
Brighton(41,994)	Hastings (27)	Brighton(1:700)
Hastings(10,107)	Brighton (12)	Lewes (1:160)
Lewes (7,184)	Lewes (9)	Rye (1:106)
Rye (3,715)	Rye (7)	Hastings(1: 75)

KENT

In Order of Population Size	In Order of Number of Admissions	Admissions per Five Years
Dover (11,922)	Tunbridge Wells(11)	Dover (1:341)
Tonbridge(10,380)	Cranbrook (9)	Tonbridge(1:260)
Cranbrook(3,844)	Tonbridge (8)	Cranbrook(1: 85)
Tenterden(3,177)	Tenterden (8)	Tenterden(1: 79)
Tunbridge Wells*	Dover (7)	Tunbridge Wells*
Pembury (1,070)	Pembury (6)	Pembury (1: 36)

* The population of Tunbridge Wells was divided between the three parishes of Frant (2,071), Speldhurst (2,640) and Tonbridge, and no separate figures were given for its population in the 1831 census. The steep increase in the population of Tonbridge since 1811 was attributed in the 1831 census to the addition of more than 500 new houses to the town of Tunbridge Wells (see Table 6).

Sources: See Table 16; Comparative Account of the Population of Great Britain in the Years 1801, 1811, 1821 and 1831; with the Annual Value of Real Property in the Year 1815: also, a Statement of Progress in the Inquiry Regarding the Occupations of Families and Persons, and the Duration of Life, as Required by the Population Act of 1830, (PP1831(348.)XVIII.1-).

TABLE 21

**Person or Persons by Whose Direction Patients Were
Admitted to Ticehurst, 1817-42**

	Men	Women
Father	16	11(1)
Husband		13(1)
Brother(s)	8	5
Man of Same Surname	5	3
Mother	3(2)	1(1)
Wife	5(1)	
Woman of Same Surname	3(1)	2
Sister	1	2(2)
Uncle	1	1
Son-in-Law		2
Uncle & Brother	1	
Brother-in-Law	1	
Daughter	1	
Sister-in-Law	1	
Male Friend	1	
Male Guardian		1
Man of Different Surname		(1)
Cousin (sex unknown)		1

Sources: See Table 16.

TABLE 22

Condition at Discharge of All Admissions,
1 August 1792 - 31 December 1843
 Numbers in brackets represent known re-admissions.

	Men	Women	Sex Unknown	All	% First Admissions
DIED	95(7)	57(7)		152(14)	16.7
DISCHARGED: Well	88(14)	95(8)		183(22)	20.1
Improved	16	30(1)	(1)	46(2)	5.1
Not improved	12(3)	8(3)	1	21(6)	2.3
Condition unknown	218(29)	200(48)	8	426(77)	46.9
UNKNOWN	45(5)	35(6)	1	81(11)	8.9
SUB-TOTAL	474(58)	425(73)	10(1)	909(132)	100
TOTAL	532	498	11	1041	100

The 1844 Metropolitan Lunacy Comissioners Report listed 1015 admissions to Ticehurst, including 132 re-admissions. Outcome of treatment was only given for first admissions, and listed 131 deaths (14.8%), 474 cures (53.7%), and 280 uncured (31.7%). When only those first admissions the outcome of whose treatment was known by 31 December 1843 were included in statistics calculated from the Ticehurst records the figures were: 117 deaths (12.8%), 179 recoveries (19.7%), 59 discharged uncured (6.5%), 63 resident in the Asylum (7.0%), 424 discharged in an unknown condition (46.7%), and 67 for whom the outcome of treatment is unknown (7.3%).

Sources: See Table 17.

TABLE 22.1

Condition at Discharge of First Admissions, 1817 - 1842
Years run 1 August - 31 July.

	DIED		DISCHARGED			UNKNOWN
	Well	Improved	Not Improved	Condition Unknown		
1817-22	20	47	6	38	6	
1822-7	17	29	13	2	23	3
1827-32	14	20	11	2	22	3
1832-7	17	12	5	4	8	3
1837-42	12	5	1	3	6	7
TOTAL	80	113	36	11	97	22
%	22.3	31.5	10.0	3.1	27.0	6.1

Sources: See Table 17.

TABLE 23Outcome of Stay for Patients Resident, 1820-40

	DIED		Well/ Improved		DISCHARGED Not Well/ Transferred		Unknown		UNKNOWN	
	M	W	M	W	M	W	M	W	M	W
1820	11	10	7	5			6	7	3	1
1825	19	8	2	6			4	4	4	
1830	21	9	3	2			6	7		
1835	24	16	3	4		2	3	1		2
1840	28	18	1	3	3	4	1	1	1	1

Sources: See Table 17.

TABLE 24

Admissions to Ticehurst, 1845-1915

Figures for House and Highlands.*

Years run 1 August - 31 July for each year. Numbers in brackets represent known re-admissions.

	Men	Women	Both	All
1845-55	26(6)	24	50(6)	56
1855-65	40(3)	39(6)	79(9)	88
1865-75	84(9)	56(15)	144(24)	164
1875-85	74(12)	75(27)	149(39)	188
1885-95	48(11)	41(7)	89(18)	107
1895-1905	46(10)	50(9)	96(19)	115
1905-15	56(8)	45(6)	101(14)	115
SUB-TOTAL	374(59)	330(70)	704(129)	833
TOTAL	433	400	833	

* From 1852 the House and Highlands were included on one licence.

Sources: Registry of Admissions, 1845-81; Register of Admissions, 1881-90; Register of Patients 1890-1907; and Civil Register 1907-19.

TABLE 25

Number of Patients Resident, 1845 - 1915

Figures for House and Highlands.*

Numbers counted 31 July for each year.

	Men	Women	Both
1845	36	28	64
1855	36	22	58
1865	31	26	57
1875	44	35	79
1885	42	36	78
1895	39	37	76
1905	43	35	78
1915	41	38	79

* See note to previous table.

Sources: See Table 24; also Register of Discharges and Deaths, 1845-90; Register of Removals, Discharges and Deaths, 1890-1908; Register of Discharges and Transfers, 1907-30; Register of Deaths, 1907-30.

TABLE 26

Marital Status of Admissions to Ticehurst 1845-1915

Figures are for House and Highlands. Numbers in brackets represent known re-admissions. Years run from 1 August - 31 July for each year.

	Single		Married		Widow/ Widower		Divorced		Not Known	
	M	W	M	W	M	W	M	W	M	W
1845-55	22(5)	16	4(1)	7		1				
1855-65	22(2)	18(5)	13	17(1)	4(1)	4			1	
1865-75	35(3)	34(7)	37(5)	14(5)	8(1)	6(3)			4	2
1875-85	46(7)	38(6)	24(5)	26(8)	3	10(13)			1	1
1885-95	27(7)	20(3)	20(4)	16(1)	1	5(3)				
1895-1905	16(6)	28(3)	25(4)	17(4)	3	3(2	1		2	1
1905-15	26(6)	23(3)	26(1)	19(3)	2(1)	3			2	

Sources: See Table 24.

TABLE 27

Age of Admissions to Ticehurst 1845-1915

Figures are for House and Highlands. Numbers in brackets refer to known re-admissions. Years run from 1 August-31 July for each year. The median age of first admissions for each ten-year period is marked with an asterisk.

	1845- 55	1855- 65	1865- 75	1875- 85	1885- 95	1895- 1905	1905- 15
MEN							
15-24	7(2)	4(1)	5	14	6	3	6(1)
25-34	3(2)	14	16(1)	14(3)	8(2)	11(2)	7(1)
35-44	*12(2)	*8(2)	*25(3)	*19(3)	*11(4)	4(2)	*16(1)
45-54	4	6	15(2)	13(4)	5(3)	*13(3)	11(4)
55-64		6	12(2)	8(1)	7	8(1)	9
65-74		2	10(1)	3	7(2)	5(2)	5(1)
75-84				1	3	1	2
Unknown			1	2(1)	1	1	
WOMEN							
15-24	7	5	7	3	1	3	3
25-34	3	7	13(2)	15	15(3)	9	7(1)
35-44	*4	*12(2)	*12(5)	*23(8)	*10(2)	11(3)	9
45-54	5	6(3)	7(5)	16(9)	8	*15(2)	*15(3)
55-64	2	6(1)	5(3)	8(4)	6(2)	6(3)	4(2)
65-74	1	3	6	6(6)		3	2
75-84	2		4	3	1	2(1)	4
85-94			1				
Unknown			1	1		1	1

Sources: See Table 24.

TABLE 28

Country of Origin of Admissions to Ticehurst, 1845-85

Figures are for the house and Highlands. Numbers in brackets represent known re-admissions. Years run from 1 August - 31 July for each year.

	1845-55	1855-65	1865-75	1875-85
UNITED KINGDOM	49(6)	78(9)	129(22)	130(26)
GERMANY	1			
INDIA		1		3(2)
BELGIUM			1	
FRANCE			1	
GREECE			1	
ITALY			1	
SWITZERLAND			1	
AUSTRALIA				3
CANADA				1
CEYLON				1
CHILE				1
UNKNOWN/NONE			5(2)	9(11)
VARIOUS(TRAVELLING)			1	1
TOTAL	50(6)	79(9)	140(24)	149(39)

Sources: Registry of Admissions, 1845-81; Register of Admissions, 1881-90

TABLE 28.1

Country of Origin of Admissions to Ticehurst 1885-1915.

	1885-95	1895-1905	1905-15
UNITED KINGDOM	76(14)	90(18)	99(12)
GERMANY	1		
ALGIERS	1		
NEW ZEALAND	1		
MALTA	(1)		
SWITZERLAND		1	
EGYPT		1	
EAST AFRICA		1	
AMERICA		1	
CANADA			1(1)
UNKNOWN/NONE	8(2)	2(1)	1(1)
VARIOUS(TRAVELLING)	(1)		
TOTAL	89(18)	96(19)	101(14)

Sources: Register of Admissions, 1881-90; Register of Patients, 1890-1907; and Civil Register, 1907-19.

TABLE 28.2

Place of Origin of Admissions to Ticehurst from within the United Kingdom, 1845-85.				
Figures are for House and Highlands. Numbers in brackets represent known re-admissions. Years run from 1 August - 31 July for each year.				
	1845-55	1855-65	1865-75	1875-85
ENGLAND:				
London	11(1)	25	36(1)	35(8)
Sussex	11	13(5)	21(11)	29(11)
Kent	10(2)	13(2)	20(4)	17(5)
Surrey	3	8	17	14(1)
Middlesex	5(1)		5	1
Essex	2	1(1)	2	1
Lancashire	(2)		3	1(1)
Hampshire	2	1	1(1)	
Isle of Wight	1		(1)	3
Somerset	1		2	2
Norfolk	1	1	1(1)	1
Northamptonshire	1		1	1
Yorkshire		3	3(2)	4
Cheshire		1	1	2
Devon		(1)	1(1)	1
Warwickshire		1	2	1
Hertfordshire		1		2
Bedfordshire		1	1	
Berkshire		1		1
Buckinghamshire		1	1	
Nottinghamshire		2		
Cumbria		1		
Huntingdonshire		1		
Staffordshire		1		
Cambridgeshire			3	
Suffolk			3	
Gloucestershire			1	2
Worcestershire			1	1
Dorset			1	
Durham				2
Cornwall				1
Lincolnshire				1
Oxfordshire				1
SCOTLAND	1	1	1	3
WALES		1		1
IRELAND			1	2
TOTAL	49(6)	78(9)	129(22)	130(26)

Sources: See Table 28.

TABLE 28.3

Place of Origin of Admissions to Ticehurst from within
the United Kingdom, 1885-1915

	1885-95	1895-1905	1905-15
ENGLAND:			
Sussex	13(3)	26(5)	41(3)
London	28(2)	24(5)	23(2)
Kent	14(1)	19(2)	15(4)
Surrey	3	7(2)	2
Yorkshire	4(3)	1(1)	3
Dorset	1(1)		4(1)
Berkshire	2(1)	2	
Hampshire	1(1)	2	1
Northamptonshire	1	1	1
Nottinghamshire	1	1(1)	
Wiltshire			2(1)
Buckinghamshire	1	1	
Durham	(1)		1
Lancashire	1	(1)	
Oxfordshire	1		1
Warwickshire	1		1
Somerset	1		
Staffordshire	1		
Suffolk	(1)		
Cambridgeshire		1	
Cheshire		(1)	
Devon		1	
Essex		1	
Leicestershire		1	
Lincolnshire		1	
Shropshire		1	
Hertfordshire			1
SCOTLAND	3		2(1)
WALES			1
IRELAND	1		
TOTAL	76(14)	90(18)	99(12)

Sources: See Table 28.1.

TABLE 29

Former Occupations of Admissions to Ticehurst, 1845-85

Figures are for the House and Highlands. Numbers in brackets represent known re-admissions. Years run from 1 August - 31 July for each year.

	1845-55	1855-65	1865-75	1875-85
<u>WOMEN</u>				
<u>INDEPENDENT:</u>	9	7(1)	3(1)	4
Gentlewoman	8	29(5)	33(12)	8(2)
No occupation/none	3		9(1)	13(6)
Lady			5(1)	7(6)
Living at home				1
Clergyman's wife/daughter			2	
Colonel's wife/daughter				1
Barrister's wife/daughter			1	
Solicitor's wife/daughter				1
Merchant's wife/daughter		1		1
Publisher's wife/daughter		1		
Hotel Keeper			1	
Lady's Companion	1			
<u>EDUCATION: Governess</u>			1	1
Teaching				1
Schoolmistress				(1)
Butcher's daughter	1			
Servant	1			
Wife		1		1
Spinster				1
Unknown	1		1	35(12)
<u>MEN</u>				
<u>INDEPENDENT:</u>	1(2)	6(2)	6(3)	1(1)
Gentleman	2(1)	9(1)	18	6
None/no occupation			2	2(1)
No profession	1			
<u>CHURCH: Clergyman</u>	7(1)	2	8(3)	4
Clerk in Holy Orders		1	3	3
Dissenting Minister		1		
Deacon	1		1	
Priest				1
Student				1
<u>ARMY:</u>	1	1	2	
Major		1		
Cavalry Officer			1	
Colonel	1		3	1
Captain	1	2	5	4(1)
Lieutenant				2(1)
<u>NAVY:</u>		1		
Commander				2
Captain				1
Lieutenant	1			

Student	1			
<u>MEDICINE:</u> Physician	1	3	1	
Medical Man			4	
Asylum Superintendent		1		
Surgeon	1	1	1	
Surgeon-Dentist		1		
Student			1	
<u>LAW:</u>	1			
Barrister		2	5	1(3)
Solicitor			2(1)	
Student	1	1	1	
<u>AGRICULTURE:</u>				
Malster				1
West Indian Planter				1
Coffee Planter				1
Squatter				1
<u>MERCHANTS & MANUFACTURERS:</u>				
Merchant	2	3	5	4
Wine Merchant				1
Cornfactor	1			
Manufacturer			1	
Silk Manufacturer	(2)			
Snuff Manufacturer				1
Varnish Manufacturer			(1)	
Lime Manufacturer			1	
Cotton Spinner				1
<u>FINANCE & COMMERCE:</u>				
Gentleman Dept. Public Banks	1			
Gentleman Banker			1	1
Banker			1	
Stockbroker		2		
Secretary Joint Stock Co.			1	
Underwriter	1	1		
Business				1
Commerce				1
<u>ENGINEERS:</u>				1
Civil Engineer			2(1)	1(2)
Wharfinger			1	
Polyglott & Oriental Printer			1	
Bookseller	1			
<u>CIVIL SERVICE:</u> Diplomat				2
Indian Civil Service			1	
War Office Clerk				1
Judge's Clerk			1	(2)
Hotel Clerk	1			
<u>EDUCATION:</u> Tutor			1	
Junior Fellow Cambridge			1	
Student at Oxford			1	
Student	1		1	2
Pupil	1			
Unknown		2	2	17(1)

Sources: See Table 28.

TABLE 29.1

Former Occupations of Admissions to Ticehurst 1885-1915

Figures are for the House and Highlands. Numbers in brackets represent known re-admissions. Years run from 1 August - 31 July for each year.

	1885-95		1895-1905		1905-15	
	M	W	M	W	M	W
<u>INDEPENDENT:</u>						
Prince			1			
Lady				5		
Gentleman/woman	5(3)	11(1)	7(2)	7(2)	2	1
Magistrate K.C.					1	
MA Oxford					1	
None	1(1)	1	5(1)	16(3)	9(3)	26(4)
<u>CHURCH:</u>						
Bishop	1					
Doctor of Divinity					(1)	
Clergyman/Clerical	2				1	
Clerk in Holy Orders	1(1)		8(3)		2	
Priest	1					
<u>ARMY:</u>						
General	2					
Major					1	
Officer	2		2			
Colonel	1				2	
Lieutenant-Colonel			1			
Captain	1(1)		2		1	
Lieutenant	1					
<u>NAVY:</u>						
Captain					1	
Lieutenant					1	
Midshipman					1	
Lieutenant(RNLI)	1					
<u>MEDICINE:</u>						
Physician	1					
Medical Practitioner (or wife)				1	1	
Hospital Nurse				1		
<u>LAW:</u>						
Barrister	1(2)		(1)		3	
Solicitor	1		2(1)		2	
Conveyancer	1					
<u>AGRICULTURE:</u>						
Planter			1			
Land Steward	1					
Australian Farmer					1	
Farmer					1(1)	
Student	1				1	
<u>MERCHANTS & MANUFACTURERS:</u>						
Merchant (or wife)	1		1	(1)	2	
Merchant & Ship-owner					2	
Tobacco Merchant	1					
Wine & Cigar Merchant					1	
Wine Merchant	1					

Corn & Brick Merchant		1				
Coal-owner	(1)					
Manufacturer	1					
Brewer		3				
Button Manufacturer					1	
Worsted Spinner					1	
<u>FINANCE & COMMERCE:</u>						
Business	1					
City Gentleman	1					
Stockbroker						
(or wife)	1		1		1(1)	
Insurance Broker						
(or wife)		1		1(1)		
Insurance Promoter					1	
Ship Broker					1	
Fur Broker					1	
Produce Broker					1	
Commission Agent					1	
Banker	1	2				
Bank manager						
(or wife)			1			
Accountant		1				
Manager Orient S.S.Co.					1	
<u>ENGINEERS:</u>						
Civil	1(1)	(1)			(1)	
Mechanical & Sanitary		1				
Naval Architect					1	
Architect					1	
Chemist		1				
Literary Man	1					
Printer					1	
<u>CIVIL SERVICE:</u>						
Diplomatic Service	1					
India Civil Service					1	
Clerk in War Office					1	
Clerk		1				
Police Supt, Ceylon					1	
<u>CLERKS:</u>						
Gentleman-Clerk		1				
Clerk					1	
<u>EDUCATION:</u>						
Governess				1		
Schoolmistress						1
Missionary worker				1		
Wife						2(1)
Housewife				1		
Spinster				1		2
UNKNOWN	13(1)	29(6)	3(1)	13(2)	4(1)	13(1)
TOTAL	48(11)	41(7)	46(10)	50(9)	56(8)	45(6)

Sources: See Table 28.1.

TABLE 30
Supposed Causes of Insanity: First Admissions 1845-85

	1845-55	1855-65	1865-75	1875-85	TOTAL
UNKNOWN	30	23	37	52	142
MORAL	8	26	41	38	113
PHYSICAL	9	22	38	42	111
MIXED			4		4
NONE GIVEN	3	8	20	17	48
TOTAL	50	79	140	149	418

Sources: See Table 28.

TABLE 30.1
Supposed Causes of Insanity: First Admissions
Divided by Sex 1845-85

	1845-55		1855-65		1865-75		1875-85		TOTAL	
	M	W	M	W	M	W	M	W	M	W
UNKNOWN	16	14	10	13	23	14	30	22	79	63
MORAL	4	4	13	13	28	13	20	18	65	48
PHYSICAL	6	3	13	9	21	17	16	26	56	55
MIXED					2	2			2	2
NONE GIVEN		3	4	4	10	10	8	9	22	26
TOTAL	26	24	40	39	84	56	74	75	224	194

Sources: See Table 28.

TABLE 30.2
Supposed Causes of Insanity: First Admissions 1885-1915

	1885-95	1895-1905	1905-15	TOTAL
PHYSICAL	28	30	35	93
MORAL	32	30	29	91
UNKNOWN	20	14	17	51
MIXED	1	6	14	21
NONE GIVEN	8	16	6	30
TOTAL	89	96	101	286

Sources: See Table 28.1.

TABLE 30.3
Supposed Causes of Insanity: First Admissions
Divided by Sex 1895-1915

	1885-95		1895-1905		1905-15		TOTAL	
	M	W	M	W	M	W	M	W
PHYSICAL	16	12	16	14	15	20	47	46
MORAL	17	15	15	15	15	14	47	44
UNKNOWN	11	9	6	8	13	4	30	21
MIXED		1	4	2	11	3	15	6
NONE GIVEN	4	4	6	10	2	4	12	18
TOTAL	48	41	47	49	56	45	151	135

Sources: See Table 28.1.

TABLE 30.4

Moral and Physical Causes of Insanity 1845-85											
Listing only those causes which could be grouped in categories which occurred more than once.											
	1845-55		1855-65		1865-75		1875-85		TOTAL		
<u>PHYSICAL:</u>	M	W	M	W	M	W	M	W	M	W	T
Illness	1	1	1	4	9	5	4	7	15	17	32
Childbirth/ Climacteric*				4		8		15		27	27
Hereditary	3	1	8	1	4	1	4	4	19	7	26
Accident/ Injury	1	1	1	4	9	5	4	7	10	5	15
Intemperance/ Intoxication	1		3	1	3	1	1	1	8	3	11
Hot or Cold Climate			3	1	2	1			5	2	7
Self Abuse			2		1		1		4		4
Old Age								2		2	2

* Including amenorrhoea, dysmenorrhoea etc..

MORAL:

Over-Study/Work	2	3	2	8	5	6	1	17	10	27
Anxiety/Fear		1	1	6	3	5	4	12	8	20
Business Anxiety				5		5	1	10	1	11
Disappointment/ Loss	1	3	1	4	1			5	5	10
Bereavement		1	5	1	1			2	6	8
Religion	1	2	1	2	1		1	4	4	8
Excitement/ Irritability				3	1			3	1	4
Irregular Living	1	1		1				3		3
Shock/Fright				1	1			1	1	2

Sources: See Table 28.

TABLE 30.5

<u>Moral and Physical Causes of Insanity 1885-1915</u>									
Listing only those causes which could be grouped in categories which occurred more than once.									
	1885-95		1895-1905		1905-15		TOTAL		
<u>PHYSICAL:</u>	M	W	M	W	M	W	M	W	T
Illness	7	5	8	2	10	8	25	15	40
Childbirth/ Climacteric*		1		9		6		16	16
Heredity	1	6	1	3	1	4	3	13	16
Drink/ Intemperance	3		3		6	1	12	1	13
Old Age/ Senility			1	1	4	6	5	7	12
Accident/ Injury	3		2		3		8		8
Sunstroke/ Hot Climate	2		3		1		5		5
Adolescence					2	1	2	1	3
Masturbation			1		2		3		3
Sexual						2		2	2

* Including amenorrhoea, dysmenorrhoea etc..

MORAL:

Mental Stress/ Overstrain	1	1	1	3	19	11	21	15	36
Worry	2	1	2	4	2	1	6	6	12
- about family		3	2	2			2	5	7
- about work	4		2		2		8		8
Overwork/Study	3	2	6	2	3	2	12	6	18
Bereavement		3	2	2		1	2	6	8
Excitement/ Shock	2	2		2			2	4	6
Previous Attack			1	3		1	1	4	5
Disappointment in Love/Marriage		3		1		1		5	5
Financial Disappointment	2	1			1		3	1	4

Sources: See Table 28.1.

TABLE 31
Diagnoses of First Admissions to Ticehurst 1845-85

	1845-55	1855-65	1865-75	1875-85
DELUSIONS	27	51	39	20
MANIA	6	7	37	61
MELANCHOLIA	9	6	27	40
DEMENTIA	1	2	15	9
IMBECILITY	4	2	2	2
NERVOUS DISORDERS		2	4	10
MORAL INSANITY				2
NO DIAGNOSIS GIVEN	3	9	18	5

Sources: See Table 28.

TABLE 31.1
Diagnoses of First Admissions to Ticehurst 1885-1915

	1885-95	1895-1905	1905-15
MANIA	38	35 ⁱ	28
MELANCHOLIA	22 ⁱⁱ	26	14 ⁱⁱⁱ
DELUSIONAL INSANITY*	10 ^{iv}	8	25 ^v
DEMENTIA	7	6	13
GENERAL PARALYSIS	7 ^{iv}	7	5
OTHER INSANITIES*	3	2	4
MORAL INSANITY	1	2 ^{vi}	1
DEMENTIA PRAECOX			1
NO DIAGNOSIS GIVEN	1	10	10

* Before 1895 'Delusional Insanity' continues to include some patients who were diagnosed simply as suffering from 'Delusions' or 'Hallucinations'; 'Other Insanities' includes 'Insanity of Adolescence', 'Hysterical Insanity', 'Insanity of Persecution', 'Senile Insanity' etc..

i 4 of these '& delusions'; 1 '& hystero-epilepsy'.

ii 1 of these '& delusions'.

iii 1 of these 'Hypochondriasis'.

iv 1 of each of these '& partial dementia'.

v 1 of these '& hypochondriasis'.

vi 1 of these 'Insanity of Conduct'.

Sources: See Table 28.1.

TABLE 32

Length of Stay of Admissions to Ticehurst, 1845-1915
 Years run from 1 August-31 July for each year. Number in brackets represent re-admissions. The median length of stay for each decade is marked with an asterisk.

	1845 -55	1855 -65	1865 -75	1875 -85	1885 -95	1895- 1905	1905 -15
Up to 7 days	2	3	2	1	1	1	6
1+ - 4 weeks	1	12	4(1)	5(3)	3	3(1)	4
4+ - 13 weeks	6	8(3)	14(4)	31(8)	15(1)	10(1)	7
13+ - 26 weeks	3(1)	15	16(5)	30(13)	14(3)	18(2)	13(2)
26+weeks-1 year	7(2)	10(3)*	29(5)	19(5)*	10(6)	12(3)	24*
1+ - 2 years	7*	11	21(2)*	15(5)	12(4)*	11(3)*	13(1)
2+ - 5 years	8(1)	6(3)	22(3)	21(3)	10(1)	16(3)	13(4)
5+ - 10 years	3(1)	4	7(1)	5	5(1)	7(2)	6(1)
10+ - 20 years	6	2	9(1)	10(1)	11(2)	5(1)	3(1)
20+ - 35 years	4	7	5(1)	8	3	8(1)	(1)
35+ - 55 years	3(1)	1	10(1)	4(1)	2	1	
55+ years			1				
Unknown					3	4(2)	12(4)
TOTAL	50(6)	79(9)	140(24)	149(39)	89(18)	96(19)	101(14)

Sources: See Table 25.

TABLE 33

Length of Stay of Those Resident in Ticehurst, 1845-1915
 Figures counted for 31 July for each year. The median length of stay for each year is marked with an asterisk.

	1845	1855	1865	1875	1885	1895	1905	1915
Up to 7 days								
1+ - 4 weeks								
4+ - 13 weeks			1	1			1	
13+ - 26 weeks	1		1	2	3		1	3
26+weeks-1 year	1	2	3	4	2	1	2	2
1+ - 2 years	3	1	2	5	1	5		4
2+ - 5 years	3	1	10	9	10	4	3	5
5+ - 10 years	3	3	4	4	1	2	7	7
10+ - 20 years	13	11	5	13	15	17	12	22*
20+ - 35 years	20*	19*	12*	11*	16*	19*	29*	21
35+ - 55 years	16	18	16	26	27	25	21	11
55+ years	4	3	3	4	3	1	2	2
Unknown								1
TOTAL	64	58	57	79	78	76	78	79

Sources: See Table 25.

TABLE 34

Person(s) Referring Patients to Ticehurst, 1845-1905*

Years run from 1 August-31 July for each year.

	Men %	Women %	Both %
Spouse	20.0	23.5 ⁱ	21.7
Brother(s)	19.8 ⁱ	16.0 ⁱ	18.0 ⁱⁱ
Father	14.9	12.3	13.7
Sister(s)	3.5	10.3 ⁱⁱⁱ	6.8 ⁱⁱⁱ
Other Male Relative(s)	8.1	4.0	6.1
Son(s)	4.9	6.6 ^{iv}	5.7 ^{iv}
Mother	4.6	6.3	5.4
Brother(s)-in-Law	4.9	4.3	4.6
Man of Different Surname ^v	6.0	1.2	3.6
Other Female Relative(s)	2.7	4.0	3.3
Man of Same Surname	3.2	2.6	2.9
Person of Same Surname (sex unknown) ^{vi}	1.4	2.6	2.0
Other ^{vii}	2.2	1.7	2.0
Unknown	2.2	1.7	2.0
Woman of Different Surname ^{viii}	0.5	2.6	1.5
Woman of Same Surname	1.1	0.3	0.7

* Details of the relationship between the patient and the person referring them were not generally given in the Civil Register, 1907-19.

i Including one by both a brother and a brother-in-law

ii Including two by both a brother and a brother-in-law

iii Including one by both a sister and a male cousin

iv Including one by both a son and a daughter

v Including friends, solicitors, guardians etc.

vi Including cousins

vii Lunatic by inquisition, referred by Chancery Court etc.

viii Including lady's companion, mother superior etc.

Sources: See Table 24.

TABLE 35

Voluntary Boarders Admitted to Ticehurst, 1890-1914

Patients admitted for treatment as voluntary boarders between 1 January 1890 and 31 December 1914. Numbers in brackets represent re-admissions.

	Men	Women	Both
From certificates in Ticehurst	8	5	13
Former inmates admitted from home	1(1)	2(3)	7
New patients	6(1)	7	14
TOTAL	15(2)	14(3)	34

Sources: Register of Admissions, 1881-90; Register of Patients, 1890-1907; Register of Voluntary Boarders, 1890-1930; Civil Register, 1907-19.

APPENDIX 1

Articles by Herbert Francis Hayes Newington

'Notes of a Case of Insanity dependent on Syphilis', Journal of Mental Science, 19 (January 1874), pp.555-60.

'Hemiplegia in relation to Insanity', Edinburgh Medical Journal, 20 (August 1874), pp.119-23.

'Some Observations on Different Forms of Stupor and on its occurrence after Acute Mania in Females', Journal of Mental Science, 20 (October 1874), pp.372-86.

'Case of an Extraordinary Number of Convulsions in an Epileptic Patient with Remarks on Nutrient Enemata', ibid., 23 (April 1877), pp.89-95.

'Unverified Prognosis', ibid., 30 (July 1884), pp.223-33.

'The Abolition of Private Asylums', letter to the editors, ibid., 31 (April 1885), pp.138-47.

'What are the Tests of Fitness for Discharge from Asylums?', ibid., 32 (January 1887), pp.491-500.

'Hospital Treatment for Recent and Curable Cases of Insanity', Presidential Address to the Medico-Psychological Association, ibid., 35 (October 1889), pp.293-315.

'Certificates' and 'County Councils (England) and their Relation to the Administration of the Lunacy Laws', in Daniel Hack Tuke (ed.) Dictionary of Psychological Medicine (London: J. & A.Churchill, 1892), pp.189 & 275.

'Some Mental Aspects of Music', Journal of Mental Science, 43 (October 1897), pp.704-21.

'The Plans of a New Asylum for East Sussex', ibid., 46 (October 1900), pp.673-86.

With Alexander Samuel Lysaught Newington: 'Some Incidents in the History and Practice of Ticehurst Asylum', ibid., 47 (January 1901), pp.62-72.

APPENDIX 2Residential Medical Officers at Ticehurst, 1893-1917JAMES HENRY EARLS

Qualifications: LSA(1885); MCh.RUI(1887);
BAO(1890); MPC; DPH RCPSI(1899),
Queen's College Cork.

Member: Medico-Psychological Association.

Appointments: Assistant Medical Officer,
Ticehurst, 1891-3; Resident Medical
Officer, Ticehurst, 1893-6.
1896-1914 in private practice in
London and Essex.
Resident Medical Officer,
Fenstanton, Streatham, 1914- .

GEORGE FLETCHER COLLINS

Qualifications: MRCS(1885), Barts; LRCPI & LM; DPH
Cambridge (1896).

Appointments: Assistant Medical Officer Hampshire
County Asylum.
Resident Medical Officer,
Ticehurst, 1896-7.
Medical Officer of Health,
Lincolnshire, 1897- .

WILFRED ROBERT KINGDON

Qualifications: MB(1895), University of Durham;
BS(1897), King's College London.

Member: BMA and MPA.

Appointments: Resident Medical Officer, Stoke
Newington Dispensary.
Resident Assistant Northumberland
County Asylum; Assistant Medical
Officer, Birmingham City Asylum.
Resident Medical Officer,
Ticehurst, 1897-1900.
In private practice in London,
1901-14.
Then became an army psychiatrist, and
continued in service after the war.

Publications: 'Cerebral Meningitis Following
Influenza', British Medical Journal

ii (1896), pp.1143-4;
 'The Diagnosis of Hystero-Epilepsy
 from Status Epilepticus', Lancet ii
 (1898), p.320;
 'Successful Treatment of Thoracic
 Aneurisms by Large Doses of Potassium
 Iodide', ibid., ii (1903), pp.528-9.

GERALD HERBERT JOHNSTON

Qualifications: LRCS, Edin.; LRCP, Anderson's
College; LFPS, Glasgow (1893).
 Member: MPA
 Appointments: Junior Medical Officer North Riding
 Asylum, Clifton, Yorkshire.
 Assistant Medical Officer,
 Bailbrook House, Bath.
 Resident Medical Officer,
 Ticehurst, 1900-5.
 In private practice in Derbyshire,
 1905-7.
 Resident Medical Superintendent &
 Licensee, Brooke House, Clapton,
 1908- .

JOHN BASIL WALTERS

Qualifications: MRCS, LRCP(1899) Guys.
 Member: BMA and MPA.
 Appointments: Assistant Medical Officer,
 Kingsdown Private Asylum; Assistant
 Medical Officer Bailbrook House,
 Bath.
 Resident Medical Officer,
 Ticehurst, 1905.
 In private practice in London,
 1906-14; and in Buckinghamshire,
 1915-19.

EDWARD HOPE RIDLEY

Qualifications: MB, CM(1891), Edinburgh University
and Charing Cross; MD,
Edin.(1898).
 Appointments: Assistant Medical Officer North &
 West Hospital, Metropolitan Asylums
 Board.
 South African Field Force, 1900-2.
 Resident Medical Officer, Ticehurst

1905-7.
 Assistant Medical Officer,
 Portsmouth Borough Asylum, 1908-11 .

CHARLES WILLIAM JOSCELINE BELL

Qualifications: MRCS, LRCP(1884) St Thomas'; MD,
 Durham (1902).
 Member: Medical Society London.
 Appointments: Consultant Surgeon Louth Hospital,
 Lincolnshire.
 Resident Medical Officer, Ticehurst
 1907-15.

COLIN FRANCIS FREDERICK McDOWALL

Qualifications: BS(1904); MRCS, LRCP(1907); MD,
 Durham (1908).
 Member: BMA, MPA (Bronze Medal 1909) and
 Royal Society of Medicine.
 Appointments: Assistant Medical Officer Newcastle
 City Asylum; Assistant Medical
 Officer, Warwick County Asylum.
 Medical Officer, Military Hospital
 Maghull.
 Senior Assistant Medical Officer
 Cheddleton Mental Hospital.
 Resident Medical Officer, Ticehurst
 1915-17; Medical Superintendent,
 Ticehurst 1917- .
 Publications: 'Conjugal General Paralysis', Journal
of Mental Science, 55 (1909),
 pp.321-4;
 'The Leucocyte and the Acute
 Insanities', ibid., pp.726-44;
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 'Abnormal Development of Scalp',
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 'Nucleinate of Soda: Its Uses in
 Acute Mental Disorders', ibid., 62
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 'Functional Gastric Disturbance in
 the Soldier', ibid., 63 (1917),
 pp.76-88;
 'Mutism in the Soldier and its
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 pp.54-64;
 'The Genesis of Delusions: Clinical
 Notes', ibid., 65 (1919), pp.187-94.

SOURCES FOR FIGURES AND PLATES

Figure

- 1 Bill Books 1792-1802, 1802-11 and 1811-19.
- 2 ibid., Account of Patients Admitted, 1828 and the Country Register.
- 3 See Figure 2.
- 4 See Figure 2.
- 5 Bill Books 1792-1802, 1802-11, 1811-19, 1819-26, 1826-32, 1832-9, and 1840-6; Register of Discharges and Death, 1845-90.
- 6 See Figure 5.
- 7 Bill Books 1811-19, 1819-26, 1826-32, 1832-9 and 1840-6; Account of Patients Admitted, 1828; and Admission of Patients, 1843-5.
- 8 See Figure 7.
- 9 Register of Discharges and Deaths, 1845-90; Register of Removals, Discharges and Deaths, 1890-1907; Register of Discharges and Transfers, 1907-30; and Register of Deaths, 1907-30.
- 10 Registry of Admissions, 1845-81 and Register of Admissions, 1881-90.
- 11 See Figure 9.
- 12 Register of Admissions, 1881-90; Register of Patients, 1890-1907; and Civil Register, 1907-30.

Newington Family Trees

- I - III William Berry, Pedigrees of the Families in the County of Sussex, (London: Sherwood, Gilbert & Piper, 1830).
- IV - V Censuses 1851 and 1861 (H0107.1639 and RG9.570); family tree in the possession of Walter Newington.
- VI Information from Walter Newington.

Plates

- 1 - 5 Ticehurst Private Asylum for Insane Persons,
 (place of publication unknown, c.1828)
- 6 - 7 A.W.Tiffin, The Goudhurst Coronation Book
 (Tunbridge Wells: Courier Printing & Publishing
 Co., 1937), pp.170 & 228. I am grateful to
 John Symons for locating these photographs.
- 8 - 9 Family photographs in the possession of Walter
 Newington.
- 10 Case Book 33, interleaved between pp.297-8.

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East Sussex County Record Office
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Death (House), 1833-52;
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Death (Asylum), 1837-58.

Ticehurst Asylum Archives

Currently on loan to the Wellcome Institute for the
History of Medicine Library in London, but shortly to be
transferred to East Sussex County Record Office, where
they will be catalogued.

Financial Records:

<u>Bill Books</u>	1792-1802	
	1802-11	
	1811-19	
	1819-26	
	1826-32	
	1832-39	
	1840-46	
	1846-54	
	1854-61	
<u>Patients' Bill Books</u>	1863-9	<u>Ledger B (Patients'</u>
	1870-5	<u>Accounts)</u> 1870-5
	1876-81	1875-83
	1882-8	1883-91
	1889-94	1892-1901
	1895-99	1902-11
	1901-8	1912-23
	1909-17	
<u>Accounts (of Patients)</u>	1895-1910	
<u>Ledger A (Business</u>	1854-8	
<u>Accounts: salaries etc.)</u>	1869-71	
	1872-5	<u>Ledger C</u> 1874-80
	1875-9	(<u>Wage Books</u>) 1880-88
	1879-83	1889-1900
	1883-8	1901-18
	1888-92	

	1893-5
	1899-1904
	1905-18
<u>Ledger D (Rent Accounts)</u>	1864-1918
<u>Ledger E (Family Finances)</u>	1902-17
<u>Ledger F (Miscellaneous)</u>	1859-61
(Provisions)	1875-83
<u>Provisions and Necessaries</u>	1870-5
<u>Cash Books</u>	1875-8
	1880-5
	1885-90
	1890-4
	1894-6
	1897-1901
	1901-6
	1906-11
	1912-17
'Journal' (Audit Books)	1875-80
	1880-8
	1888-98
	1898-1917
'Private Journal' (Audit Book)	1898-1918
Annual Audits (loose sheets)	1863-95.
Administrative Records:	
A	<u>Account of Patients Admitted, 1828</u>
C	<u>Admission of Patients, 1843-5</u>
G	<u>Registry of Admissions, 1845-81</u>
	<u>Register of Admissions, 1881-90</u>
	<u>Register of Patients, 1890-1907</u>
	<u>Register of Voluntary Boarders, 1890-1930</u>
	<u>Civil Register, 1907-19</u>
	<u>Medical Register, 1907-30</u>
	<u>Register of Patients, 1925-30</u>
	<u>Letters Book, 1857-73 ('Case Book')</u>
H	<u>Register of Discharges and Deaths, 1845-90</u>
	<u>Register of Removals, Discharges and Deaths, 1890-1907</u>

Register of Discharges and Transfers, 1907-30
Register of Deaths, 1907-30

B	<u>Visitors' Books</u>	1833-45	
		1846-69	
		1869-87	
		1887-1904	
		1904-23	
	<u>Patients Books</u>	1846-1904	
		1904-29	
D	<u>Medical Visitation Books</u>		1842-4
E			1844-5
			1845
I	<u>Medical Journal and Weekly Reports</u>		1845-53
	<u>Medical Visitation Books</u>		1853-75
			1875-7
			1877-82
			1882-4
			1884-6
			1886-9
			1889-94
	<u>Medical Journals</u>		1895-8
			1898-1901
			1901-3
			1903-10
			1910-15
			1916-21

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Directors Attendance Book, 1918-74

Clinical Records:

<u>Case Books</u>	1	1846-51
	2	1851-4
	3	1854-6
	4	1856-8
	5	1858-60
	6	1860-1
	7	1861-2
	8	1862-3
	9	1858-63
	10	1864-5
	11	1865
	12	1866
	13	1867
	14	1867
	15	1868
	16	1869
	17	1869-72

18	1871-3	
19	1873	
20	1874	
21	1875	
22	1875	
23	1876-9	
24	1877	
25	1877-82	
26	1879-83	
27	1881-3	
28	1883-8	
29	1886-94	
30	1885-7	
31	1887-8	
32	1888-90	
33	1890-2	
34 H	1892-8	H = Hayes Newington
35 A	1892-5	A = Alex. Newington
36 A	1894-1902	J = ?
37 H	1895-1905	
38	1896-1904	
39 H	1897-1903	
40	1896-1917	Voluntary Boarders Only
41 A	1899-1911	
42 H	1899-1910	
43 A	1901-8	
44 H	1901-4	
45 A	1904-8	
46 H	1905-9	
47 A	1908-10	
48 H	1908-12	
49 A	1910-14	
50 H	1910-16	
51 J	1913-16	
52 H	1913-16	
53	1915-17	

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